FREDERICK COUNTY CPMT AGENDA

June 28, 2021
1:00 PM
107 N Kent St
Winchester, VA
Microsoft Teams Video Conference

Microsoft Teams meeting
Join on your computer or mobile app
Click here to join the meeting

Join with a video conferencing device
fcva@m.webex.com
Video Conference ID: 114 538 714 5
Alternate VTC dialing instructions

Or call in (audio only)
+1 276-221-3203,,173523502# United States, Danville
Phone Conference ID: 173 523 502#
Find a local number | Reset PIN

Agenda

I.	Introductions	
II.	Adoption of Agenda	
III.	Consent Agenda	
	A. May Minutes	
	B. Budget Request Forms	
IV.	Executive Session	
	A. None	
V.	Committee Member Announcements	
VI.	CSA Report	Jackie Jury
	A. Financial Report	
	B. SpEd Wrap Allocation	
VII.	Old Business	Jackie Jury
	A. Strategic Plan Discussion- Goal 1 Improve UR Plan	
	B. EBP Collaborative/FFPSA/CSA Integration	
	C. Vendor Contracts	
VIII.	New Business	
	A. Administrative Memo #21-10	
	B. Administrative Memo #21-11	
	C. Administrative Memo #21-12	
	D. Administrative Memo #21-13	
	E. Administrative Memo #21-14	
	F. NOIDP- Family Engagement	
	G. NOIDP- FAPT & MDT	
	H. Medicaid Memo	
IX.	Assigned Tasks	
X.	Next Meetings	

- CPMT June 28, 2021 via TBD- See Memo for future dates

XI. Adjourn

**Instructions for Closed Session:

- Motion to convene in Executive Session pursuant to 2.2-3711(A)(4) and (15), and in accordance with the provisions of 2.2-5210 of the Code of Virginia for proceedings to consider the appropriate provision of services and funding for a particular child or family or both who have been referred to the Family

Assessment and Planning Team and the Child & Family Team Meeting process, and whose case is being assessed by this team or reviewed by the Community Management and Policy Team

- Motion to return to open session-
- Motion that the Frederick County CPMT certify that to the best of each member's knowledge, (1) only public business matters lawfully exempted from open meeting requirements, and (2) only such public business matters were identified in the motion by which the closed meeting was convened were heard, discussed, or considered in the closed meeting.
- Roll Call Affirmation
- Motion to Approve cases discussed in Executive Session

CPMT Meeting Minutes: Monday, May 24, 2021

The Community Policy and Management Team (CPMT) Committee met on May 24, 2021. Members participated via Microsoft Teams video conference.

The following members were present via Microsoft Teams video conference:

- Michele Sandy, Frederick County Public Schools, Chair for Tamara Green
- Jay Tibbs, Frederick County Government
- Jerry Stallings, 26th District Juvenile Court Service Unit
- Denise Acker, Northwestern Community Services Board
- David Alley, Private Provider Representative, Grafton Integrated Health Network

The following members were not present:

- Dr. Colin M. Greene, Lord Fairfax District Health Department
- Tamara Green, Frederick County Department of Social Services

The following non-members were present:

- Jacquelynn Jury, CSA Coordinator
- Robbin Lloyd, CSA Account Specialist

Call to Order: Michele Sandy called the meeting to order at 1:04 pm.

Introductions: Members and nonmembers of the team introduced themselves.

Adoption of May Agenda: Jay Tibbs made a motion to adopt the May agenda; David Alley seconded; CPMT approved.

Consent Agenda: The following items were put in the Consent Agenda for CPMT's approval:

- April 26, 2021 CPMT Minutes
- Budget Request Forms – Confidential Under HIPAA

David Alley made a motion to approve the Consent Agenda as distributed, Jay Tibbs seconded, CPMT approved.

Executive Session: On a motion duly made by Jay Tibbs and seconded by David Alley, the CPMT voted unanimously to go into Closed Executive Session to discuss cases confidential by law as permitted by Section §2.2-3711 (A) (4) and (15) and in accordance with the provisions of 2.2-5210 of the Code of Virginia.

Account of Executive Session:

- Appeal of Copayment amount due to reported hardship.

Adoption of Motion to Come Out of Closed Session: Jay Tibbs made a motion to come out of Closed Session and reconvene in Open Session; David Alley seconded; the CPMT approved.

Motion and Roll Call Certification of Executive Session: Jay Tibbs made a motion, to Certify to the best of each Frederick County CPMT member's knowledge (1) the only public business matters

lawfully exempted from open meeting requirements and (2) only such public business matters were identified in the motion by which the closed meeting was convened were heard, discussed, or considered in the closed meeting.

Jay Tibbs	Aye
David Alley	Aye
Denise Acker	Aye
Jerry Stallings	Aye
Michele Sandy	Aye
Tamara Green	Not Present
Dr. Colin Greene	Not Present

Adoption of Motion to Approve Items Discussed in Executive Session: Jay Tibbs made a motion to deny a request to reduce the amount of a copayment assessment pending the receipt of further documentation, David Alley seconded; CPMT approved.

Committee Member Announcements:

- New director, Jerry Stallings for the Courts Services Unit was welcomed.

CSA Financial Report:

- April 2021 Financial Report
  - Spent $2,378,298.12, which includes SpEd Wrap Funds
    - $1,470,946.53 remaining without SpEd Wrap funds.
    - Served 121 youth served
      - 84 in Community Based Services
      - 24 in Private Day School
      - 20 in Congregate Care
      - 17 in TFC
    - Non-mandated Funds: $4,997.50 spent, $55,182.50.00 remaining, with $23940.00 encumbered.
    - SpEdWrap Funds: $214,361.65 spent, $22,165.04 remaining with $65,605.50 encumbered.
  - CPMT Parent Rep Resignation – Dawn Robbins has resigned from CPMT, a replacement will be sought.

Old Business:

- Tabled until June: Goal #1 UR Improvement Strategic Plan Update
- EBP Regional Learning Collaborative & FFPSA Integration Model-
  - A reminder was given that the Frederick/Winchester/Page team will have their training sessions on June 14 and 28 and participants are required to attend both classes.

New Business:

- Future CPMT meetings – The CPMT discussed returning to in person meetings as COVID-19 restrictions are being reduced statewide. The team agreed to meet virtually in June and transition

back to in person meetings beginning July FY22, based on the anticipated termination of the state of emergency by governor's orders.

- FY22 Contracts – The revised contracts are waiting for review by the county attorney. Copies of the proposed changes were provided to the CPMT. A motion was made by David Alley to approve the contracts pending legal review and with any changes recommended by the county attorney, Jay Tibbs seconded, CPMT approved.
- Administrative Memo #21-06 – Stipulates the language on legislation requiring private special education programs to be licensed by VDOE or an out of state equivalent, in order to use CSA funding.
- Administrative Memo #21-07 – Provides notification and copies of revised forms required by Medicaid beginning July1 to ensure the local Medicaid match is correctly assigned.
- Administrative Memo #21-08 – Provides a sample contract for use between DSS/CSA and vendors for the purchase of MST, PCIT, or FFT services through FFPSA funding.
- Administrative Memo #21-09 – Details a new mandated eligibility category for CSA funded services that can provide up to 12 months of transitional services in the public school setting for youth who have been placed in a Private Day School for a minimum of 6 months. Services must be identified in the youth's IEP

Next Meeting: The next CPMT meeting will be held Monday, June 28, 2021 at 1:00 p.m. via video conference.

Assigned Tasks:

- Michele Sandy will provide a copy of a presentation provided by the DOE in a meeting with local Directors of Special Education to the CSA Coordinator and schedule a time to discuss the upcoming changes.
- The CSA Coordinator will forward the email containing a short pretraining presentation for the June 14 and 28 EBP Collaborative sessions.

Adjournment: Michele Sandy made a motion to adjourn; David Alley seconded; the CPMT approved. The meeting was adjourned at 1:58 pm.

Minutes Completed By: Robbin Lloyd

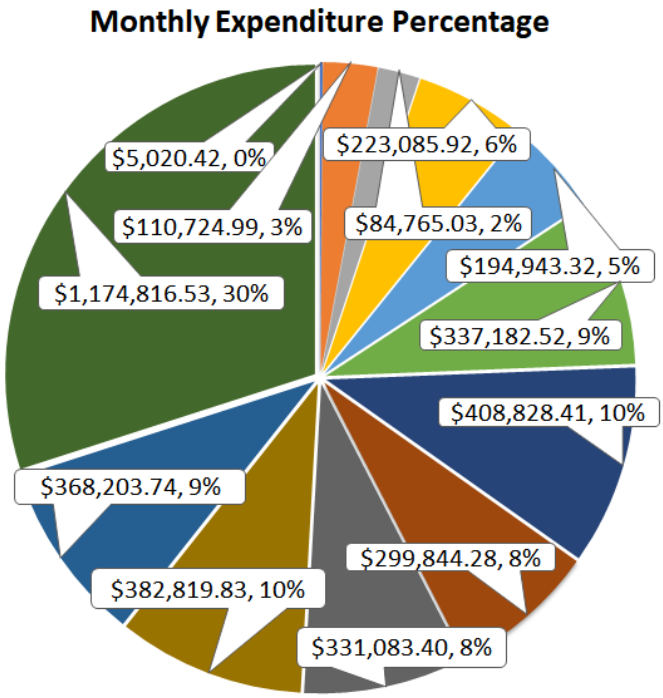
Frederick County CSA Financial Update:
May 2021

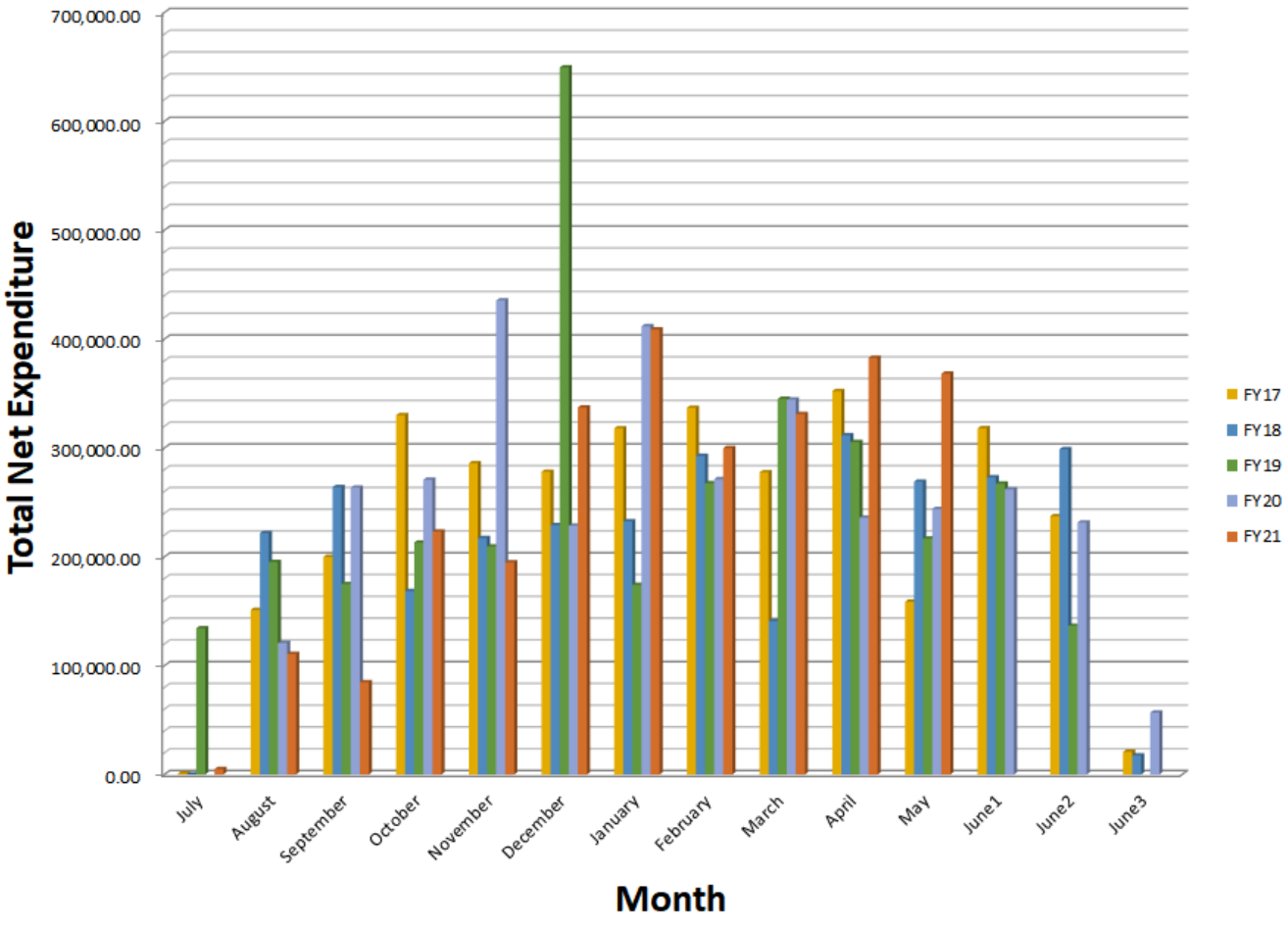
of Reports Submitted: 11

YTD Total Net Spent with Wrap:
$2,746,501.86

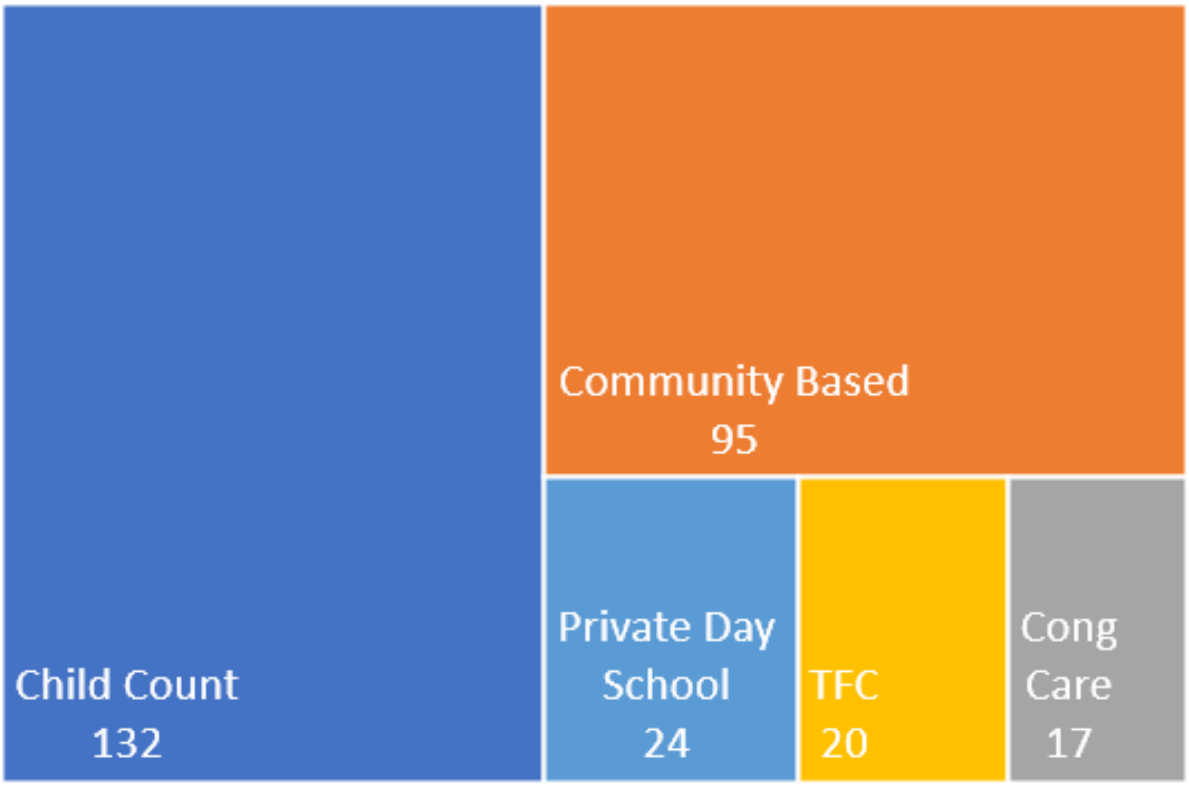
YTD Local Net:
$1,144,624.16

Remaining w/o Wrap:
$1,125,427.78





Placement Environment

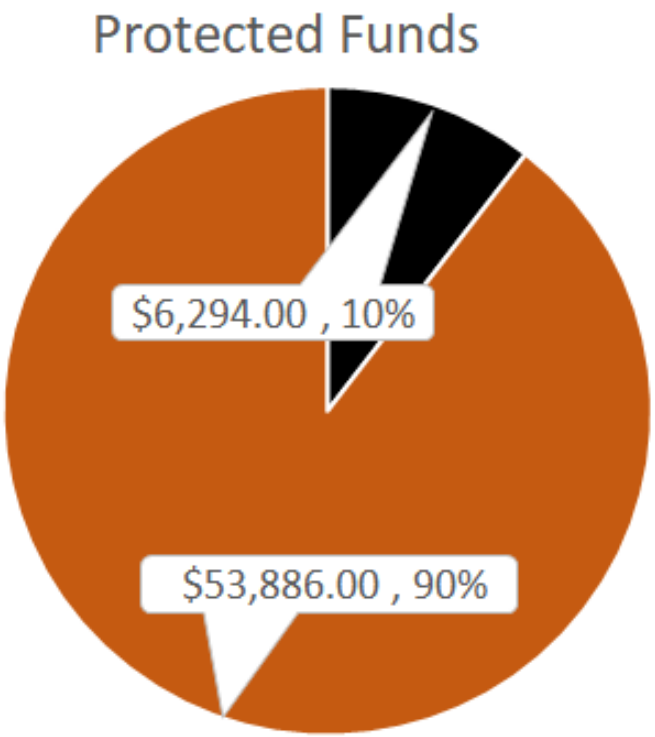


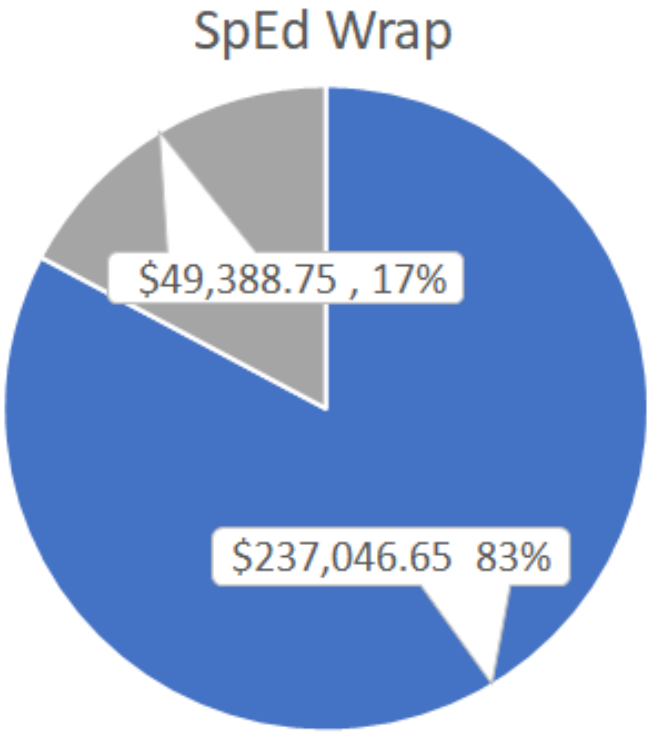
Unduplicated: Child Count, Congregate Care, Therapeutic Foster Care, Community Based Services

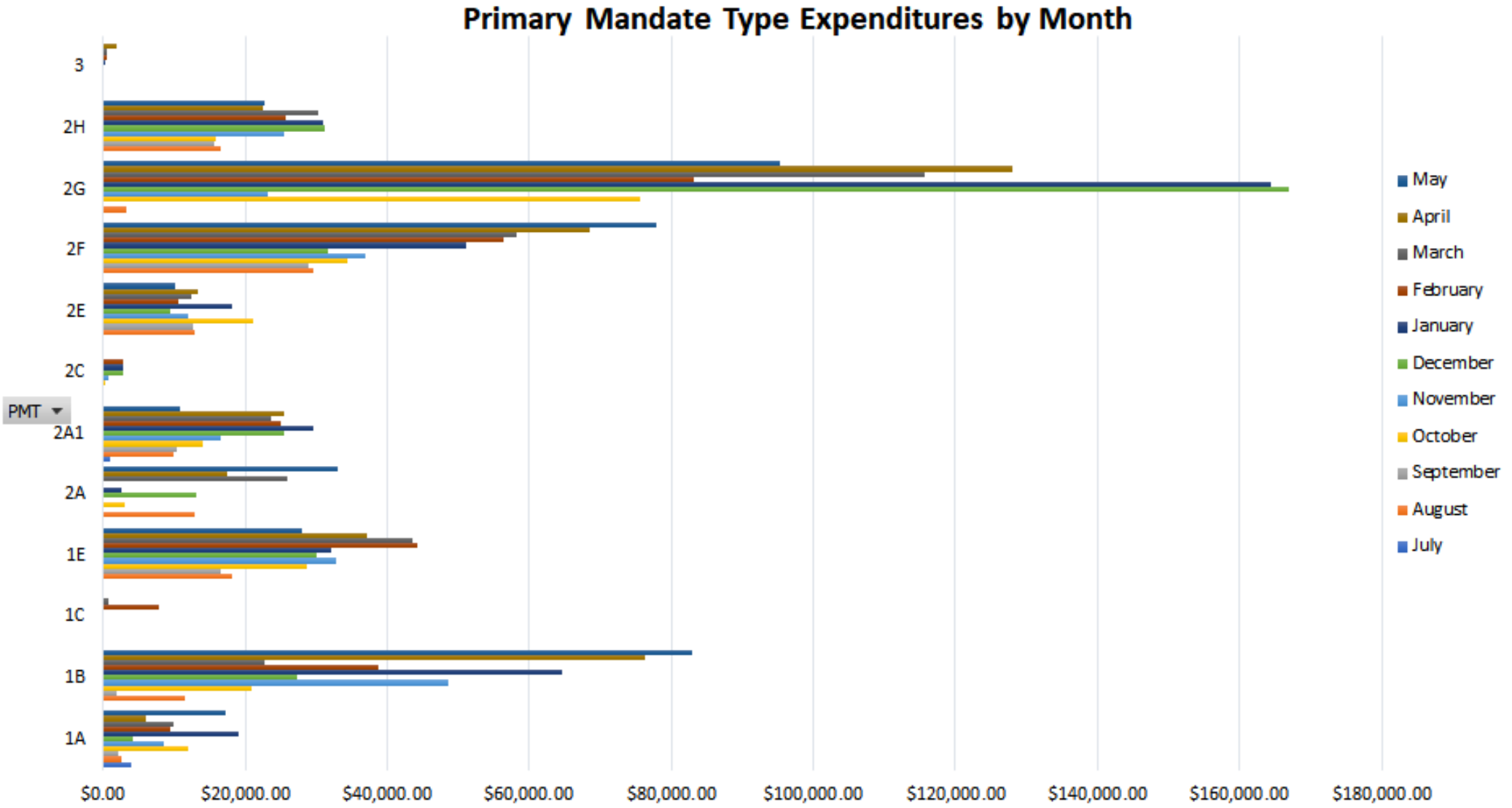
*Possible duplication of Private Day School students with youth in Congregate Care

NonMandated Encumbered: $12,474.00

SpEd Wrap Encumbered: $43,653.50







Primary Mandate Types (PMT):

1A- IV-E Congregate Care
1B- Non IV-E Congregate Care
1C- Parental Agreement Congregate Care
*PMTs from 1A-1C do not include Daily Education payment of congregate care placements

1E- Residential Education
*Includes all services for RTC IEP and Education only for all other RTC placements

2A- IV-E Treatment Foster Home
2A1- Non IV-E Treatment Foster Home
2A2- Parental Agreement Treatment Foster Home

2C- IV-E Community Based Services
*Only for youth placed in CFW Foster Homes

2E- Maintenance and Other Services
*Only Basic Maintenance and Daycare for youth in Foster Care

2F- Non IV-E Community Based Services
*Includes Daycare for youth not in Foster Care or IV-E CBS for youth placed in TFC or Cong Care

2G- Private Day School

2H- Special Education Wrap Around Services

3- Protected Funds
*NonMandated

Office of Children's Services
Empowering communities to serve youth

WRAP Request Report - Fiscal Year 2021

Locality (FIPS): Frederick (069)				**Base Rate:** 0.4348 (The rates have been rounded to ten-thoundandths place decimal)
Date Created: 05/19/2021				Date Printed: 05/28/2021
WRAP Request ID: 35				WRAP Request Status: OCS BM Fully Approved
		Actual FY 2021	**Projected FY 2021**	**Total FY 2021**
		Expenditures	**Additional Expenditures**	**Actual + Projected Expenditures**
		(*Includes Pended Pool Report)	**(b)**	**(a+b=c)**
I	2h. Wrap-Around Services for Students With Disablities	$191,815.40	$94,620.00	$286,435.40
II	Less Current Reported Wrap Refunds			$0.00
III	Net Project Wrap Expenditures (Line I - Line II)			$286,435.40
		Local Share	**State Share**	**Total**
IV	Current Total Wrap Allocation: Total dollar amount of wrap allocated for FY 2021 which includes intial and any approved wrap allocations/adjustments	$83,566.96	$108,629.65	$192,196.61
V	Wrap Allocation Funds Requested: (Line III - Line IV)	$40,975.02	$53,263.76	$94,238.79
	Requester Comments	SpEd Wrap funding is being used at an increased rate this year. As a result of the COVID-19 pandemic, some students with disabilities have struggled tremendously and decompensated behaviorally. SpEd Wrap funds have been used to support these youth and maintain them in the home, preventing IEP residential placements.		

Locality Approver Information

	Report Preparer	Jackie Jury	05/19/2021	_____
	CPMT Chair	Tamara Green	05/28/2021	_____
	Fiscal Agent	Sharon Kibler	05/28/2021	_____

OCS Latest Approved Totals

		Local Share	**State Share**	**Total**
	WRAP Request Approved by OCS Business Manager	$40,975.02	$53,263.76	$94,238.78

CSA Utilization Review: Guidelines for Best Practices

September 2020

What is Utilization Review?

Utilization Review (UR) is the formal assessment of the necessity, efficiency, effectiveness, and appropriateness of services. UR occurs at the child/family service level and in CSA, it measures the progress of the youth and family toward the goals and objectives in the Individual Family Service Plan (IFSP). UR is the process by which the IFSP and services are reviewed and recommendations provided to the Family Assessment and Planning Team (FAPT), the case manager, and/or the service provider regarding the service plan and funded services. UR is a form of checks and balances; it asks are we getting what we paid for? Are things getting better? How do we know?

UR is not a pathway to second guessing the case manager, service provider, or FAPT. UR should be a collaborative component of the service planning process. The goal of UR is not to cut costs or services, but rather to evaluate the effectiveness of services and supports. While service reductions may be an outcome of UR, in some instances UR may lead to a recommendation for an increased level, frequency, or number of services. UR should look at progress objectively to improve the outcomes for youth and families.

Is UR Required?

Yes, UR is required. Section 2.2-5206 of the Code of Virginia requires that the Community Policy and Management Team (CPMT) "establish quality assurance and accountability procedures for program utilization and funds management."

Section 2.2-5208 indicates that FAPT, "in collaboration with the family, shall provide regular monitoring and utilization review of the services and residential placements for the child to determine whether services and placement continue to provide the most appropriate and effective services for the child and family." Additionally, FAPT shall "designate a person who is responsible for monitoring and reporting, as appropriate, on the progress being made in fulfilling the individual family services plan developed for each youth and family, such reports to be made to the team or the responsible local agencies."

All localities must have a UR policy. Your policy should include a plan for how frequently UR is completed, who is responsible for completing UR, and procedures that dictate how UR is completed and recorded. The policy should also indicate who is responsible for oversight of the UR process, the manner in which oversight is managed, and how to address circumstances that deviate from the adopted practices, policies, and procedures.

CSA Utilization Review: Guidelines for Best Practices

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Utilization Review is part of your community's comprehensive Continuous Quality Improvement (CQI) Plan. CPMT can utilize trends collected at the child and family/service level to guide long range planning or policy decisions.

Who can do UR?

As noted above, the CPMT designates in its policies and procedures how UR is to be completed in their locality. There is great flexibility and many options for how the locality chooses to complete UR, and it is important that the community follow whatever plan they identify in their policies and procedures. The FAPT or the CSA Coordinator can complete UR. Some localities have an Identified UR specialist. UR can be a paper review of progress reports and related documents, a site visit, an interview with the provider, the youth, and family or a combination of any of these. However you choose to execute UR, you must have documentation of its occurrence.

UR can also be purchased as a service using CSA funds. UR can be purchased from the local CSB or a private entity. Remember, all services in CSA are child specific. As a result, if recommended by FAPT, UR can be placed on a youth's IFSP as a service, and the funding for this service can be approved by CPMT. In order to assure objectivity and avoid conflict, if purchasing UR from the CSB, the UR specialist should not be providing services to the youth and family. Moreover, if UR is purchased from a private entity, that entity should not be providing services to the youth and family.

Communities can also choose to contract with the Office of Children's Services for State-Sponsored UR (for non-educational residential placements). If your locality uses State-Sponsored UR for non-educational residential placements, you will still need to develop a plan for completing UR for community-based services and other levels of care.

What about IEP Placements?

Due to federal mandates associated with the special education process, Utilization Review for IEP placements should be completed by the IEP team and must be based upon the goals in the IEP. The CSA UR process for special education services must conform to special education laws and must not violate the Individuals with Disabilities Education Improvement Act (IDEIA) or state special education regulations. Local CSA programs can expect the school division to share the findings of the IEP review of the student's progress and this meets CSA Utilization Review requirements.

How Frequently Should UR be Completed?

Your local UR plan should specify the frequency with which UR is completed. State Sponsored UR is completed 60 days after the initial placement date and every 90 days thereafter.

The following is a sample review schedule:

Service Type	Utilization Review Frequency	CANS Administration
Foster care maintenance, including day care	Based on CPMT policy. Though not required to come to FAPT, best practice encourages a multi-disciplinary review	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy
Community-based, non-clinical services	Every 6 months	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy
Community-based, clinical services and/or a combination of two or more services	Every 3 months	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy
Intensive in-home services, Therapeutic Foster Care, ICC, or Residential (PRTF or TGH) placement	Every 3 months	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy and/or service/funding requirement
Private day special education services or IEP residential	Completed by the IEP review team	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy
Acute psychiatric (hospital)	Daily monitoring of risk and level of need	

CSA Utilization Review: Guidelines for Best Practices

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Quality Utilization Review is Guided by Four Principles:

Below are the four principles of quality UR and questions your local UR *might* ask.

1. Quality UR Begins with Quality, Strengths-Based Service Planning
   - UR is part of the service planning cycle. Developing a strong service plan (IFSP) is the foundation of quality UR. Service plans should incorporate all assessment data, be strengths driven, include a long-term goal as well as measurable objectives, include the voice of the youth and family, and convey a complete picture of the youth and family.
   - The long-term goal and objectives in the IFSP should align with the strengths and needs uncovered in the CANS and other assessment information.

2. Quality UR Examines ALL Elements of the Plan of Care
   - Thorough UR should examine the CANS, IFSP and Provider Treatment Plans; is there congruence? UR should consider if information on these documents is consistent.
   - UR should look to see if the services match the needs of the youth and family.
   - UR should identify if and how youth and family voice is reflected in the service plan.
   - UR should look for evidence of the strengths of the youth and family in the IFSP.

3. Quality UR Measures Progress, Provides Recommendations, and Monitors the Status of Recommendations
   - UR asks if the youth and family are making progress towards their long-term goals and objectives and looks for evidence of this progress. Are things getting better? How do you know? (e.g., youth and family engagement, changes in treatment goals and objectives, improvement in CANS scores, increase in number of strengths or social connectedness).
   - Are services being implemented as expected?
   - UR considers the barriers to progress; what changes are occurring to the service plan in order to address these needs?
   - UR looks for indicators of discharge planning.
   - UR asks questions and makes recommendations to the FAPT, Case Manager and/or service provider based upon review. These may focus on services, the IFSP, the involvement of the youth and the family or other components of the service planning process

4. UR is More Than Quality and Cost of Services
   - UR is a strategy to improve your local System of Care. Themes uncovered during UR are opportunities improve local service planning. For example, UR might identify a pattern of youth transitioning from residential to the community and then needing to return to residential; your locality could consider changes to the local service planning process.

How will local service planning improve transition planning? What changes are needed with provider relationships or community supports? What is the level of family engagement?

- Findings and trends at the service level can inform the CQI process of the CPMT. In the example above, if UR identifies a pattern of youth transitioning from residential to the community and then needing to return to residential, CPMT might consider long-range planning goals related to use of congregate care or recidivism. They also might ask if a focus on building community supports and resources is needed? (As this might help with transitioning and maintaining youth at home)
- UR can also identify bright spots of service planning, practices you want to be sure to continue. For example, we always ensure to incorporate parent voice in IFSP's as evidenced by one objective in their words.
- UR should capture family and youth satisfaction with services and the CSA process. This information should guide and improve local practices, policies and procedures.

UR is an Ongoing Cycle

Utilization Review is an ongoing process. UR is not a one-time event, but rather a continuous process that repeats itself throughout the youth and family's involvement with CSA. Feedback, recommendations, and questions raised by UR should facilitate dialogue resulting in improvements in the service delivery and outcomes for youth and families.

Tools and Resources for UR:

OCS developed a Model IFSP UR Addendum for local use. This form can be completed at a FAPT meeting or by anyone charged with completing UR. The Model IFSP UR Addendum incorporates best practices of UR identified in these guidelines. It can be found on the CSA website in the Resources Tab under Forms. A Sample (completed) IFSP UR Addendum can be found in the resources section of this document.

Your community is encouraged to develop a Family Satisfaction Survey. As noted in these guidelines, feedback from youth and family members regarding services and the local CSA process should be utilized to guide service planning as well as local policies and procedures. A sample survey is in the resources section of this document.

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CANVaS 2.0 System Reports

The CANVaS 2.0 system hosts a series of reports that may be useful for carrying out Utilization Review of children and families receiving services through CSA. The Individual Progress Report (IPR) compares a child's ratings on their Initial CANS to the two most recently completed CANS and may be converted to a graph for a visual comparison. The Permanency Report (available only for the DSS-Enhanced CANS) provides a similar comparison of Initial CANS to the two most recently completed CANS for each Caregiver rated. This report organizes the items by the five Protective Factors found in the Strengthening Families model. The Permanency Report also provides a listing of which items have "improved" from a "2" or "3" to a "0" or "1" at the last rating period so areas of improvement may be quickly noted. These reports are available to case managers who have entered at least one assessment for the child into the system.

The suite of "Longevity Reports" available to the CANVaS Local Administrator includes an additional individual child progress report (Individual Collaborative Formulation) that has multiple filters to allow more flexibility than the IPR in comparing items across assessments. The remaining four Longevity Reports provide aggregate data for the locality, so will be most helpful with community assessment and long range planning. The Item Breakout report identifies a cohort of children with treatment needs (scores of "2" and "3") by date of Initial assessment and compares to a second assessment, noting what percentage of children show the need is continuing, what percentage show improvement or worsening and what, if any, children show a new treatment need. The Multi-level Collaborative Formulation report identifies the items most endorsed in the locality as treatment needs from the Life Functioning, Emotional/Behavioral Needs, and Child Risk domains allowing for a quick look at what raters have noted are the primary needs in the community. The Strengths Development report measures whether or not the aggregate assessments reflect progress in strength-building for the children in the locality. Lastly, the Average Impact report reflects whether there is overall improvement in aggregate treatment needs.

Complete descriptions of these reports are found in the CANVaS 2.0 Report Manual, which is located in the "Documents" folder of CANVaS and on the OCS website at www.csa.virginia.gov/CANS .

Resource Materials

CSA Utilization Review: Guidelines for Best Practices

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Locality Utilization Review Self-Assessment

1. My locality uses needs and strengths from the CANS (and other assessments) to develop service plans

   Yes No

2. My locality develops service plans that include a long term goal and measurable objectives

   Yes No

3. The service plans my locality develops include the voice of the youth and family

   Yes No

4. My locality follows a schedule to review the service plan

   Yes No

5. We track progress towards the goal and objectives in the service plan

   Yes No

6. We monitor progress in services

   Yes No

7. The youth and family's perspective on progress (in services and towards the goal and objectives) is collected

   Yes No

8. We provide recommendations for service planning and monitor for implementation of those recommendations

   Yes No

9. We discuss and plan for discharge throughout the service planning process

   Yes No

10. We collect feedback from youth and families about the CSA process and purchased services

    Yes No

CSA Utilization Review: Guidelines for Best Practices

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Utilization Review Might Ask….

When Examining the Plan of Care:

- Are the IFSP, provider service plans, and assessment information congruent?
- Does the current CANS match the clinical, behavioral, and social presentation of the youth and family?
- Do the recommended/purchased services match the needs identified in assessment?
- Are the strengths and needs of the youth and family guiding the objectives and goals?
- Is there an IFSP goal and objectives?
- Is the family and youth voice and participation reflected in the IFSP?

When Measuring Progress:

- Are the youth and family progressing towards identified goals in treatment plan? How do you know? (How is progress measured?)
- If not, what are the barriers/needs towards goal achievement? What steps will be taken to meet these needs?
- Are provider treatment goals updated to reflect progress?
- Is there are clear discharge plan?
- What work is occurring to achieve the discharge plan?
- Is the IFSP updated to reflect needs, strengths and progress?
- Are there changes in CANS scores?
- Is the overall level of functioning (family and youth) improving? How do you know?
- What changes have occurred in service delivery because of UR recommendations?
- What steps has the FAPT taken to incorporate/consider recommendations from previous reviews?

CSA Utilization Review: Guidelines for Best Practices

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Local CSA Family Satisfaction Survey

At the FAPT meeting, I was treated with dignity and respect:

Yes No

I knew what to expect (who would be there, where they would sit, where I would sit, what would be discussed and how long it would last) before I attended the FAPT meeting:

Yes No

At the FAPT meeting, I was encouraged to share the strengths and needs of my family:

Yes No

My views about my family's strengths and needs guided decisions made at the FAPT:

Yes No

During the FAPT meeting, they used language I understood and I understood the decisions made about my family:

Yes No

I knew who to call and (how to reach them) if I had questions or concerns about CSA:

Yes No

The bright spot of CSA is/was:

The greatest challenge of CSA is/was:

What else would you like to share about your experience with CSA?

CSA Utilization Review: Guidelines for Best Practices

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Local CSA Family Satisfaction Survey

The services and supports provided were helpful to my family

Yes No

How have the services provided helped your family?

What concerns do you have regarding the services provided?

How is the service provider planning with you for discharge from the service?

How is the service provider connecting you to community resources?

What else would you like to share about the services provided to your family?

CSA Utilization Review: Guidelines for Best Practices

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(Sample) Office of Children's Services (Sample)

State Sponsored Utilization Review
Initial Utilization Review

Client: Name Replaced

DOB/Age: Age: 16

Social Security #:

CSA Contact Person: Name Replaced

CSA Locality: Name Replaced

Service Provider: Residential Facility

Admission Date: 4/23/2015

Reporting Period: Initial

Review Date: 8/2/2015

Date of Most Recent CANS Administration: 4/29/2015

Case History and Reason for Placement:

Name Replaced is in the custody of Name Replaced DSS. Name Replaced was ordered into foster care in April 2015 following a probation violation. Prior to placement in foster care, Name Replaced resided with his paternal grandmother. This was a short term placement following the disruption of placement with his maternal grandparents after their home was raided and a "meth lab" was discovered.

Submitted documentation reports that Name Replaced is on probation following an incident of "rape, sodomy, and kidnapping of a 9 year old girl." It is also written that Name Replaced has a substance abuse history and that his paternal grandmother "could not control Name Replaced and his behaviors."

Residential Facility documentation reports that "Name Replaced currently needs the Residential Facility placement to develop a trusting relationship, provide stability, supervision and structure in order to assist him with his intensive needs."

Diagnosis (if available):

None provided

Psychological Evaluation Findings (if available):

None Provided

Current Medications:

None Provided

Services Utilized in the Past:

Submitted documentation reports that Name Replaced previously attended sex offender treatment "but was removed from the treatment due to lack of participation and missing too many sessions." Prior to placement in the Residential Facility, Name Replaced was placed in detention on two occasions (January 2015 and April 2015) for probation violations.

Client and Family Strengths:

Per CANS:

Child: Family, Optimism, Educational, Talents/Interest and Involvement with Care.

Family: Involvement with Care, Residential Stability, Mental Health, Substance Use, Developmental, Accessibility to Child Care Services, Family Stress, Self-Care/Daily-Living, Educational Attainment, Legal, Financial Resources, Transportation, and Safety.

Per IFSP:

Name Replaced has a desire for a fresh start. He has expressed the need for drug treatment and the willingness to comply with services. Name Replaced's mother and grandmother are supportive of him.

Per Residential Facility Service Plan:

Name Replaced is very engaging, can articulate what he needs and is currently motivated.

Treatment Concerns/Challenges:

Submitted documentation references a serious sexual offending charge ("rape, sodomy, and kidnapping of a 9 year old girl) for Name Replaced.

Submitted documentation identifies significant substance abuse needs for Name Replaced and his family.

SERVICE PLAN REVIEW (includes Foster Care Plan, if applicable)

Include description and notes related to progress or lack of progress for each goal:

IFSP Goals/Objectives	Service Provider Goals/Objectives
Goal 1: "Name Replaced will return home to his grandmother once his behaviors have stabilized and his services are well established." **Objective**: Name Replaced will participate in all recommended services while in foster care, including sex offender treatment. Name Replaced will also maintain his relationships with his grandmother, mother, and brother.	**Goal 1**: "Name Replaced will identify reasons that he was placed on probation and reasons for substance use, and will discuss and utilize coping strategies to refrain from substance use and will follow all rules of probation." **Progress** as noted on the Residential Facility May 2015 Progress Report: Name Replaced has been very open regarding his history and reasons for substance use. He continues to be open and cooperative with KPACT and Residential Facility mother. He has followed rules of probation and is working on completing his community service.
Goal 2: "Name Replaced will complete a psychological evaluation to assess and further needs." **Objective:** Name Replaced will keep any appointments related to his psychological assessment.	**Goal 2**: "Name Replaced will follow the rules and regulations of the Residential Facility and will participate in family activities." **Progress** as noted on the Residential Facility May 2015 Progress Report: Name Replaced had followed all rules and participated in all family activities of the Residential Facility. He has increasingly interacted with the family and he appears more comfortable in the home.
Goal 3: "Name Replaced will remain substance free." **Objective:** Name Replaced will work with his Life Coach to develop healthy ways to cope instead of using drugs.	

Is the local CSA case manger participating in Service Planning/Treatment Team meetings with the service provider?
If so, how?

The submitted documentation does not provide this information.

Is service provider participating in FAPT Meetings? If so, how?

The submitted documentation does not provide this information

Discharge Plan:

The Residential Facility Plan dated May 2015 states that the "the focus of Name Replaced's placement is to help him stabilize and integrate into the Residential Facility and community while maintaining the goal to return to his mother."

Name Replaced's IFSP states that "Name Replaced will return home or step down to a TFC home once his behaviors have stabilized and he has well established services. The target date for this transition is 12/31/15."

Recommendations:

Submitted documentation states that Name Replaced's mother will need to complete substance abuse treatment and a parenting class before Name Replaced can return to her. It is written that Name Replaced's mother is "very involved and is also cooperating with DSS"; however information about her completion/enrollment in required treatment is not mentioned. Is Name Replaced's mother enrolled in substance abuse treatment? What about Name Replaced's grandparents? Submitted documentation states that his mother was in the home of his grandparents when it was raided as a "meth lab". This same documentation writes that both Name Replaced's mother and grandparents tested positive for substances. Did Name Replaced's mother reside with his grandparents? Is this the home that Name Replaced will return to? As a result of the above referenced "meth lab", one wonders about the importance of Name Replaced's grandparents also completing substance abuse treatment.

It also seems important to ensure that Name Replaced and his mother have opportunities to engage in services together prior to his return home. What opportunities exist or will exist for Name Replaced and his mother to receive family therapy or other treatment services to address the family system needs (supervision and the creation of a home that is safe, productive, and free of triggering situations and people)? In order for Name Replaced to successfully return home (maintain in the community, be free of substances, not engage in additional criminal behavior) it seems essential to ensure that Name Replaced and his mother have opportunities to engage in services together.

It is noted in the Residential Facility Progress Report that "beginning in June, DSS will begin to schedule supervised visitations with mom and grandmother"; have these visitations occurred? What needs/strengths have been uncovered as a result of these visitations?

What does Name Replaced and his mother and grandmother enjoy doing together? What are their interests? How do they spend time during visitation? Name Replaced CANS identifies Talents/Interest as a strength; what is/are his talents/strengths? What opportunities does he have to participate these activities? Are these activities that he can do with his mom/grandmother? How can his talent/interest be used to build their relationship? In addition to treatment services, deepening Name Replaced's relationship with mom and grandmother and increasing the pro-social activities they engage in seems an important component of service planning.

Submitted documentation references a serious charge for Name Replaced related to sexual offending behavior (rape, sodomy, and kidnapping of a 9 year old girl). The need for Name Replaced to participate in sex offender treatment is referenced, however, submitted documentation does not provide information regarding Name Replaced's level of engagement or progress in his sex offender treatment. Is Name Replaced compliant with this treatment? What level of progress has occurred? One also wonders about Name Replaced's risk of re-offending? When planning Name Replaced's discharge, transition, or future services, it seems essential to understand his level of progress as well as future risks related to sexual offending behavior.

Name Replaced's IFSP writes that a psychological evaluation will be completed. Has this evaluation occurred? What were the diagnostic impressions and treatment recommendations that resulted from the evaluation?

The May 2015 Residential Facility Progress Report writes that the discharge/step down date for Name Replaced is December 2015. This discharge/transition is related to the stabilization of Name Replaced's behaviors and ensuring that "he has well established services", however, measurable objectives and treatment needs are not provided. Name Replaced's most recent Residential Facility Progress Report writes of ongoing positive engagement in services. This raises the following questions:

- At what point will Name Replaced be ready for transition to a lower level of care? How will the locality/provider know that Name Replaced is ready for this transition? (What are the treatment/behavioral objectives that will indicate that Name Replaced is ready for this transition?)
- What is needed for Name Replaced to achieve these treatment objectives?
- What efforts are occurring to plan for his discharge/transition to a lower level of care?
- What will Name Replaced need in order to transition to a lower level of care?

- What is Name Replaced's vision for his transition from his residential placement? Who does he identify as his helpers achieve this vision? What does he identify as his needs?

Utilization Review Consultant: Anna Antell, LCSW

Next Review Date: November 2, 2015

CC: CPMT Chair

(Sample) Office of Children's Services (Sample)

State Sponsored Utilization Review
Subsequent Utilization Review

Client: Name Replaced

DOB/Age: Age: 14

Social Security #:

CSA Contact Person: Name Replaced

CSA Locality: Name Replaced

Service Provider: Residential Facility

Admission Date: 6/25/2015

Reporting Period: September 2015-January 2016

Review Date: 1/8/2016

Date of Most Recent CANS Administration: 12/10/2015

Case History and Reason for Placement:

The Case History and Reason for Placement was summarized in the Initial Desk Review completed in September 2015.

Diagnosis (if available):

DSM V Diagnosis:

296.89 Other specified bipolar disorder

309.81 Posttraumatic stress disorder

298.8 Other specified psychosis

Bilateral patellofemoral pain

Severe Stressors (early childhood abuse, neglect, and abandonment), current family conflict

(Per Residential Facility Individual Plan of Care dated 9/24/2015)

Psychological Evaluation Findings (if available):

No report is noted or provided.

Current Medications:

Lamictal - 150mg, twice daily

Seroquel XR- 100 mg every evening

(Per Residential Facility Individual Plan of Care dated 9/24/2015)

Services Utilized in the Past:

The Service Use History was summarized in the Initial Desk Review completed in September 2015.

Client and Family Strengths:

Per CANS:

Child: Educational, Talents/Interest, and Involvement with Care,

Family: Supervision, Involvement with Care, Knowledge, Organization, Social Resources, Residential Stability, Physical Health, Mental Health, Substance Use, Developmental, Accessibility to Child Care Services, Family Stress, Self-Care/Daily Living, Employment/Educational Functioning, Educational Attainment, Legal, Financial Resources, Transportation, and Safety.

Per IFSP:

"Name Replaced is interested in art and writing. Name Replaced is intelligent both academically and cognitively. Name Replaced understands her need for treatment and has begun work towards her treatment goals."

Per Residential Facility Individual Plan of Care:

"Gifted, intelligent, and very supportive adoptive family"

Current Treatment Concerns/Challenges:

The September 2015 Residential Facility Individual Plan of Care writes that "during this reporting period Name Replaced continues to struggle to ask for staff support at times." This document also states that "the staff encourage her to be more assertive and stop apologizing for everything as well as creating crises when affected by negative peers."

The October 2015 IFSP writes that "Name Replaced has not been calling her mother consistently while being placed at Residential Facility and has been avoiding difficult

conversations surrounding treatment. Ms. Mother has participated in a majority of family therapy via telephone."

The submitted State Sponsored UR Checklist writes that "Name Replaced continues to struggle with mood dysregulation, self-harming behaviors, and suicidal ideations and needs to remain at Residential Facility."

Current Treatment Strengths/Progress:

The September 2015 Residential Facility Individual Plan of Care writes that "during this reporting period, Name Replaced continues to interact appropriately on the unit and she is mindful of her boundaries, Also she continues to on being assertive when communicating her wants and needs." This report also writes that "unit staff reports significant progress in Name Replaced's behavior since admission as she interacts well with staff, follows redirection well, she interacts well with peers and shows signs of leadership."

The submitted State Sponsored UR Checklist writes that "Name Replaced has developed a healthy, trusting relationship with her therapist at the facility. Name Replaced is receptive to working toward her goal of expressing her emotions regarding her strained relationship with mother. She is demonstrating good coping skills during stressful situations regarding disagreements with other residents at the facility."

The October 2015 IFSP states that Name Replaced "has improved in her level of optimism and has been able to identify positives about herself. Name Replaced has also become more involved with her treatment and has identified her challenges. She has decreased her oppositional behaviors and anger." This document also writes that "Name Replaced reported that she has been better about honest with her therapist and teacher, and has been honest during treatment."

GOALS/OBJECTIVES REVIEW (includes Foster Care Plan if applicable)

Include description and notes related to progress or lack of progress for each goal:

ISFP Goals/Objectives	Provider Goals/Objectives
Long Term Goals: 1. Name Replaced and her family will communicate by expressing their feelings to each other in a healthy and appropriate manner. 2. Name Replaced will develop appropriate coping strategies to express her emotions and feelings and use them in her daily life. 3. Name Replaced will eliminate self-harm behaviors and suicidal ideations	**Goal 1**: Name Replaced will be able to cope effectively without engaging in suicidal or self-injurious thoughts/behaviors (including withholding, bingeing, and purging food) within 90 days of discharge. **Objectives:** Use effective communication by consistently verbalizing her needs. Complete Chapter 3 in DBT skills workbook. **Progress** as noted on the Residential Facility Individual Plan of Care dated 9/24/2015: Name Replaced has identified desire to increase ability to ask for what she needs in place of shutting down or becoming overwhelmed with emotion. Continue work on DBT skills. Interpersonal effectiveness with regard to mindfulness in conversation will be a focal point.
	Goal 2: Name Replaced will externalize thoughts and feelings related to trauma/stress so as to no engage in any verbal/physical aggression or property destruction within 90 days of discharge. **Objectives;** Ability to follow first prompt 75% of the time. Identify and practice verbalizing 3 positive affirmations. **Progress** as noted on the Residential Facility Individual Plan of Care dated 9/24/2015: Name Replaced has earned and maintained level 5 of 5. Name Replaced has expressed anxiety about being able to follow staff's directions and would like to be encouraged to do so over the next review period. Name Replaced has processed challenges and reports a readiness and willingness to begin developing positive affirmations to support positive self-esteem.

	Goal 3: Name Replaced will appropriately express her thoughts and feelings as well as implement assertiveness skills with her family instead of holding her feelings inside until she reacts aggressively or with deception 90 days prior to discharge. **Objectives:** Name Replaced and her mother will process Name Replaced's emotional block to treatment progress. Name Replaced will practice externalizing thoughts and feelings by using "I" statements and appropriate eye contact. Name Replaced will initiate discussion of at least one treatment goal-related topic during weekly family therapy sessions. **Progress** as noted on the Residential Facility Individual Plan of Care dated 9/24/2015: Name Replaced and her mother begun to identify emotional blocks. Name Replaced acknowledges that she often tries to find the "right" answer rather than speaking authentically.

Is the local CSA case manger participating in Service Planning/Treatment Team meetings with the service provider? If so, how?

Submitted documentation indicates that the CSA Case Manager participates in Treatment Meetings by phone.

Is service provider participating in FAPT Meetings? If so, how?

Submitted documentation indicates that the provider participated in FAPT by phone.

Discharge Plan:

Name Replaced's IFSP writes that "Name Replaced indicated to the team that she will be ready to return home when she is able to be honest with herself and others, more confidence in herself and her ability, not allowing her past to define her and continuing to apply what she has learned."

The Residential Facility Individual Plan of Care dated 9/24/2015, states that discharge criteria are the following: "Name Replaced will be free from all self-harm (including binging/purging/

restricting) for 60 days prior to discharge. Name Replaced will be free from all aggression for a period of 60 days prior to discharge. Name Replaced will be able to use honest, effective communication with her mother in place of lying or withholding her thoughts and emotions 30 days prior to discharge. Name Replaced will participate in several successful TLOA, gradually leading up to overnight, to determine readiness for discharge."

Recommendations:

Submitted documentation provides evidence of strong progress by Name Replaced in her treatment at Residential Facility*. While it is understood that Name Replaced has additional treatment needs that require ongoing residential placement, the locality is still encouraged to begin thinking about Name Replaced's discharge from residential treatment. Given the intensity of Name Replaced's pre placement behaviors, successful discharge planning will require collaborative, deliberate, and individualized planning. Such planning will be most effective if it begins as part of Name Replaced's treatment at Residential Facility.*

Name Replaced's ability to return and maintain at home will require that she internalizes her treatment gains and can apply the skills learned at Residential Facility *in varied settings. Providing Name Replaced with opportunities to be with her family in their home and in the community provide chances to utilize these skills. Submitted documentation writes of one off campus pass for Name Replaced and her mother; has Name Replaced had additional opportunities to be outside of the residential facility with her mother?*

Name Replaced's successful return home will also depend heavily on her mother's ability to provide permanence for her. Submitted documentation describes a significant level of at-risk and self-harming behaviors by Name Replaced prior to placement at Residential Facility*. Family therapy seems a crucial service to prevent Name Replaced and her family from returning to previous maladaptive patterns upon Name Replaced's return home (thus jeopardizing Name Replaced's permanence within the family). Submitted documentation writes that "it is recommended that Mother follow therapist's recommendations for participating in person versus via phone for family therapy sessions". Has Name Replaced's mother been able to follow through with this recommendation? If not, what are the barriers to accomplishing this task? What does Name Replaced's mom and/or Name Replaced feel is needed in order for face-to-face family therapy to occur?*

Name Replaced has many strengths and documentation notes several interests for Name Replaced. When thinking about Name Replaced's discharge from Residential Facility, the locality is encouraged to ensure that Name Replaced's strengths and interests are incorporated into the discharge planning process. By nurturing Name Replaced's strengths and interests (in addition to planning for her treatment needs), the treatment team will promote Name Replaced's

resiliency and help Name Replaced to develop natural supports. Resiliency and supports will enhance Name Replaced's wellness and self-care. This writer wonders what opportunities exist or can be created for Name Replaced to participate in activities or groups related to writing, art, and poetry? Connecting Name Replaced with such activities or groups might provide opportunities for Name Replaced to develop positive social support. It also seems important to ask Name Replaced about her vision for these interests and talents; how would she like to use them? What about Tae Kwon Do and basketball? Inquiring about Name Replaced's interest to continue these activities and finding opportunities to incorporate them into transition planning seems important.

Name Replaced appears vocal and insightful about her treatment needs and progress. As a result, it seems essential that a discharge plan incorporate Name Replaced's voice. This writer wonders what Name Replaced would say discharge should look like? Meaning what is her vision for discharge? Who are her supports? What/who helps her when things are going well? Name Replaced's IFSP includes Name Replaced's perspective on when she will be ready to return home (honesty with self and others, confidence in herself and her ability, not allowing her past to define her, and continuing to apply what she has learned); this writer wonders what Name Replaced feels she needs in order to accomplish these tasks? Who does she feel can help her accomplish these things? What will it look like/how will she (and the team) know that she has return home ready (meaning how can her "vision" for returning home be measured)?

Noted actions/changes taken in response to most recent UR:

The submitted State Sponsored UR Checklist provides a response to the questions posed in the Initial UR completed in September 2015.

Utilization Review Consultant: Anna Antell, LCSW

Next Review Date: April 8, 2016

CC: CPMT Chair

CSA Utilization Review: Guidelines for Best Practices

September 2020

UR Date: select date **Client Name:** last, first

(Locality Name)
(Sample) Utilization Review Addendum to the IFSP (Sample)

Demographic Information:			
Client Name: Elizabeth Jones	**Client ID #:** (_)	**DOB:** 8/3/2006	**Age:** 14
Review Date: 4/24/2020	**Last Review Date:** Initial UR	**Reporting Period:** Initial	
Service Provider: (provider name)		**Admission Date:** 1/24/2020	
Date of Most Recent CANS: (select date)		**Date of last FAPT:** 4/5/2020	

Evaluations/Diagnoses/Medications
Evaluations: Psychological Evaluation – February 2020- Provided details regarding depression diagnosis and treatment needs.
***Diagnoses*:** Major Depressive Disorder, Recurrent, Moderate, Disruptive Mood Dysregulation Disorder, Alcohol Use Disorder, Cannabis Use Disorder, Difficulties with caregiver and school
Medications: Escitalopram 20mg, 1/day, Clonidine .2mg, nightly

Historical Information
Case History: Elizabeth was initially referred to FAPT by her CSB Case Manager following an increase in high risk behaviors such as skipping school, self-injurious behaviors (cutting), substance use (alcohol and smoking marijuana) and suicide ideation. Elizabeth's aunt (her guardian) was concerned about recent increase in frequency and intensity of Elizabeth's behaviors.

CSA Utilization Review: Guidelines for Best Practices

September 2020

Service History: : Elizabeth has received outpatient counseling and case management from the CSB since February 2018. Elizabeth also received medication management from the CSB and this began in June 2018. Elizabeth began IIH services in March 2019 following multiple interactions with the Emergency Services Department at the CSB and one acute hospitalization in January 2019. Despite IIH services, she was acutely hospitalized again in June 2019 and November 2019.

Rationale for Current Services: Due to the escalating concerns regarding Elizabeth's at-risk behaviors despite involvement with multiple community-based services, Elizabeth was placed in residential treatment in January 2020. In order to prepare for Elizabeth's return home, As of April 2020, Elizabeth's aunt has been connected with a Parent Coach and has been connected to the local NAMI Chapter. Elizabeth requires treatment for the at-risk behaviors (self-harm, suicide ideation, substance use) associated with her mental health diagnosis and Elizabeth's aunt needs assistance to ensure she is equipped with the necessary skills to manage Elizabeth in the home.

Youth and Family Strengths

Per the Youth: I am independent. I am a fighter. I like to draw.

Per the Family: Per Aunt: I am committed to Elizabeth. She is indeed a strong young lady.

Per the Case Manager (CANS): Elizabeth: Family- Elizabeth's aunt is invested in her care. Talent/Interest- Elizabeth enjoys drawing and plays trumpet. Spiritual/Religious- Elizabeth's aunt is very involved in their church. Elizabeth previously participate in the church youth group. Involvement with Care-Elizabeth acknowledges that she wants things to be better. Aunt: Involvement with Care, Organization, Social Resources (connected to her church), Residential Stability, Developmental, Self-Care/Daily Living, Employment, Legal, Transportation and Safety.

Per FAPT (IFSP): Elizabeth's aunt has been an advocate and caregiver for Elizabeth for many years. She is committed to Elizabeth and has always tried to find support and help. Elizabeth has interests in the arts that can be helpful in planning for her transition home.

Per the Provider: Elizabeth expresses a desire for things to get better. She wants to succeed. Elizabeth's aunt has participated in family therapy and calls Elizabeth several times per week.

Youth and Family Needs and Treatment Concerns

Per the Youth: I want to stop feeling so much pain.

Per the Family: Elizabeth needs to be stable enough that she can safely be at home and school.

CSA Utilization Review: Guidelines for Best Practices

September 2020

Per the Case Manager (CANS): Elizabeth: Depression, Substance Use, Self-Harm, Suicide Ideation, School Attendance and Family relationships. Aunt: Supervision, Knowledge, Physical and Mental Health (as a result of the stress related to Elizabeth's needs) and Family Stress

Per FAPT (IFSP): Elizabeth's depression needs to be stabilize and she needs to develop the inner and community resources to manage her symptoms of depression. Elizabeth needs to reduce the engagement in self-harming skills and be clean from alcohol and drugs. Elizabeth's aunt needs to increase her understanding of Elizabeth's mental health needs, the connection between her behaviors and her mental health. Elizabeth's aunt will also need support and skill development to plan for Elizabeth's return home.

Per the Provider: Ongoing treatment for Elizabeth to develop Coping Skills for depression and specifically to reduce self-harm. Ongoing SA treatment. Family therapy for Elizabeth and her aunt.

Service Plan Review:

Date of most recent treatment team: (select date)
Did youth participate? ☒Yes ☐ No
Did parent/guardian participate? ☒ Yes ☐No; if yes, ☐ in person or ☒by phone
Did case manager participate? ☒Yes ☐No; if yes, ☒ in person or ☐by phone

Goals & Objectives:

Family Goal:

For Elizabeth to return home and stay home. To understand her depression and how to help her stay safe.

IFSP Goals/Objectives	*Service Plan Goals/Objectives*
Goal/Objective 1: Elizabeth will increase her level of participation in treatment in her RTC by attending at least two groups weekly and one individual therapy session weekly. **Progress:** Elizabeth refused several group, family and individual sessions this review period. Her mood continues to fluctuate which impacts her level of engagement.	**Goal/Objective 2:** Elizabeth will return to the community with improved insight into mood instability and how it is related to behavior. **Progress:** Elizabeth's mood continues to fluctuate. She expresses a desire for improvement, but has not yet been able to engage deeply enough in treatment to facilitate change.
Goal/Objective 2: Elizabeth's aunt will participate in parent coaching twice per week in order to build engagement with her parent coach. **Progress:** New Objective, service just beginning.	**Goal/Objective 2:** Elizabeth will return to the community with increased coping skills to deal with life's stressors. She will be able to utilize these skills instead of resorting to self-harm behaviors. **Progress:** Needs to attend therapy three times/week as well as weekly self-harm group as indicated in treatment plan in order to develop needed coping skills.

Goal/Objective 3: Elizabeth will draw at least once daily. **Progress:** New Objective- Objective added at FAPT after Elizabeth shared that the "quiet time" on the milieu is hard because she is "in her head".	**Goal/Objective 3:** Elizabeth will return to community with increased knowledge of her substance use behavior to include triggers. She will return armed with positive coping skills to utilize when faced with these triggers. Elizabeth will need to be connected to a local SA group. **Progress:** Elizabeth says she will remain clean when she leaves the RTC. She has not yet been willing to acknowledge that she will need supports, skills and resources to do this.
Goal/Objective 4: (goal/objective #4) **Progress:** (progress)	**Goal/Objective 4:** Elizabeth will return to the community with improved communication, self-expression and relationship skills. This will be evidenced by increase positive communication with her aunt. **Progress:** Elizabeth's aunt calls several times a week. She has participated in family therapy. So far these sessions are more like "check-in's" and need to evolve into more treatment.

Discharge Plan/Progress Toward Discharge:	
Discharge to: Aunt's Home	**Proposed Discharge Date:** 11/1/2020
Family's involvement in discharge: Elizabeth's aunt calls several times weekly and participates in family therapy. She remains invested in Elizabeth's treatment.	
Summarize discharge planning efforts: Elizabeth's aunt has been connected with the local NAMI Chapter to build her social support network and grow her understanding of Elizabeth's mental health needs. Elizabeth's aunt has also been connected to a Parent Coach. This service will help Elizabeth's aunt to outline and plan for her needs as well as the household needs as it relates to Elizabeth's return home.	

CSA Utilization Review: Guidelines for Best Practices

September 2020

Recommendations:
It is positive that service planning is addressing both the needs of Elizabeth and her aunt. While it is clear that Elizabeth has ongoing treatment needs, her needs will not end upon completion of the RTC and it will be essential that her aunt further develop the knowledge and skills to support these needs. The CANS identifies Supervision, Knowledge, Physical and Mental Health and Family Stress as needs for Elizabeth's aunt. As a result, it seems important that Parent Coaching focus on these needs. Additionally, Social Resources is identified as a strength for Elizabeth's aunt- the team is encouraged to consider how further connection with Elizabeth's aunt's church can be part of transition planning for Elizabeth. It is also positive to see that an objective has been added to Elizabeth's treatment regarding drawing. While engagement in treatment is important, it also seems important to ensure that Elizabeth has opportunities to use her strengths; to do things that make her feel good and provide a sense of accomplishment and fulfillment. This writer wonders if Elizabeth has the necessary resources to draw? This writer also wonders if there is more information that can be learned about Elizabeth's interest in drawing; what does she like to draw? What does she use as her materials for drawing? Is it an activity she enjoys doing with others? Could drawing be an opportunity to further build or repair her relationship with her aunt? Provider documentation notes difficulties by Elizabeth with engagement in treatment. How is the RTC adjusting treatment to increase Elizabeth's level of engagement? What new treatment strategies are offered? Documentation notes ongoing fluctuations in mood; are there adjustments needed to Elizabeth's medication?

Next Review Date:
7/24/2020

Review Completed By: (name and title)

COMMONWEALTH of VIRGINIA

Scott Reiner, M.S.
Executive Director

OFFICE OF CHILDREN'S SERVICES
Administering the Children's Services Act

ADMINISTRATIVE MEMORANDUM #21-10

To: CPMT Chairs
CSA Coordinators
CSA Fiscal Agents

From: Scott Reiner, Executive Director

CC: Elizabeth Lee, Assistant Director, Division of Family Services, VDSS
Alyssa Ward, Ph.D., Behavioral Health Director, Virginia DMAS

Date: May 24, 2021

Subject: CSA Guidance Re: Congregate Care Placements – Effective July 1, 2021

There are several changes with regard to CSA funding for congregate care placements for youth in foster care taking effect on July 1, 2021. These changes stem from two sources, the change in Medicaid policy regarding the use of Title IV-E funds in psychiatric residential treatment facilities (previously addressed in OCS Administrative Memo #20-11) and the implementation of the Family First Prevention Services Act.

The guidance document attached to this memo addresses both of these issues and is important for your local CSA programs to understand and implement. OCS will also be scheduling a webinar in June to provide any needed clarification and to answer questions you may have.

Please read the attached document carefully and let us know if you have any specific questions.

What CSA Programs Need to Know about the Use of Medicaid, Title IV-E, and Implementation of the Family First Prevention Services Act (FFPSA) as it Applies to Children in Foster Care and Congregate Care Placements

(Congregate Care Guidance)

Office of Children's Services

Effective Date: July 1, 2021

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I. Applicability

This document contains information specific to the activities of the Children's Services Act (CSA) with regard to the placement of children in foster care into congregate care settings (psychiatric residential treatment facilities (PRTF) and group homes).

The information reflects changes in payment responsibilities for PRTFs resulting from policy determinations made by the Department of Medical Assistance Services, (DMAS or Medicaid) and addressed in Office of Children's Services' Administrative Memo #20-11, issued on November 20, 2020.

This document also addresses changes to policies and practices in the state and local departments of social services resulting from the implementation of the Family First Prevention Services Act (FFPSA), and specifically, the Qualified Residential Treatment Program (QRTP). Information on specific FFPSA requirements for local departments of social services for congregate care placements that do not directly impact CSA should be found in the appropriate VDSS guidance documents (i.e., Section 6B. of the VDSS Foster Care Guidance) and will not generally, be repeated here.

II. Background[1]

The Family First Prevention Services Act, or FFPSA, is a significant change in federal child welfare law impacting the placement of children in foster care in congregate care placements, including psychiatric residential treatment facilities (PRTF), therapeutic group homes (TGH), and children's residential facilities (CRF).[2]

Concerning congregate care placements, the FFPSA intends to:

1) disincentivize the use of such placements by instituting restrictions on the use of federal child welfare funds (i.e., title IV-E) to support such placements; and

2) improve outcomes for children in foster care placed in these settings by instituting a series of requirements to raise the quality of care.

The CSA system of care approach and its practitioners promote and advocate for community-based services. There are instances where a higher level of support is required to meet the needs of a child. In such circumstances, a non-family-like (congregate care) setting may be most appropriate. The system of care and the FFPSA encourage non-family-based placements to be short-term, focusing on individual children's needs, and preparing them for return to family and community life.

[1] FFPSA also affects the provision of and funding for services to prevent placement in foster care. That "side" of FFPSA isdiscussed in other guidance documents.
[2] PRTF and TGH placements are licensed/regulated by the Department of Behavioral Health and Development Services. CRF placements are licensed/regulated by the Department of Social Services.

A. Requirements to be designated as a QRTP

The FFPSA establishes a series of requirements for a congregate care facility to be designated as a Qualified Residential Treatment Program (QRTP) and eligible to receive federal (and matching state) title IV-E funding. The requirements to become a QRTP include a trauma-informed treatment model, accreditation approved by the Children's Bureau (the federal title IV-E oversight agency), on-site or accessible medical and clinical staff available 24 hours a day seven days a week, outreach to families, and family-based aftercare support. These requirements are detailed in the Virginia Department of Social Services' Family First webpage and are found here: https://familyfirstvirginia.com/foster_care/qrtp.html.

- Also at that site is a Frequently Asked Questions (FAQ) document regarding QRTPs: (https://familyfirstvirginia.com/foster_care/qrtp_faq.html) and
- A list of those programs designated or being considered for designation as a QRTP: (https://familyfirstvirginia.com/foster_care/qrtp_applicants.html).

B. Requirements of the Placing Agency (VDSS and LDSS)[3]

In addition to using QRTP-designated facilities, there are several necessary practice changes at the local department of social services to meet the FFPSA requirements for congregate care placements. These are:

- Within 30 days of a child's placement in a QRTP, an assessment must be performed by a "qualified individual" to determine if the placement is appropriate.
- Within 60 days of a placement in a QRTP, a court review must take place to approve or disapprove the placement, based on a judgement of whether the child's needs can be met through placement in a foster family home and whether or not the QRTP provides the most effective and appropriate level of care.
    - If the court does not approve the placement, the LDSS has 30 days from the date of the court hearing to move the child. Title IV-E or CSA funds (depending on the child's tile IV-E eligibility) may be used during these 30 days.
    - If the court does not hold a hearing with 60 days of the placement, title IV-E funding can be used only for the first 60 days.[4]
- A QRTP placement must be reviewed by the VDSS Commissioner with a specified period (12 months if a youth in foster care 13 years of age or older and six months if the youth in foster care is 12 years of age or younger).

[3] Specific details of these DSS requirements can be found in VDSS Foster Care Guidance, Section 6B.
[4] Title IV-E funding cannot be utilized in a Psychiatric Residential Treatment Facility (PRTF), regardless of the facility's status as a QRTP. Title IV-E funds may be used in group home settings only.

Responsibilities in the event of a failure to meet these VDSS/LDSS requirements are discussed in Section V of this document.

Note: Certain specialized, non-QRTP congregate settings may utilize title IV-E funds.[5] These include:

- Placements for pregnant and/or parenting youth
- Specialized placements for youth at risk and victims of sex trafficking
- Family-based residential treatment facilities for substance use disorder

Note: The FFPSA allows the use of title IV-E funds for congregate care placements for up to 14 days, independent of whether the placement is designated as a QRTP or one of the other specified settings. After the first 14 days of placement, an alternative funding source (e.g., Medicaid, CSA state pool) would need to be utilized if the placement does not meet a placement setting outlined in the FFPSA and VDSS Title IV-E Guidance (Section 1.8). QRTP placements must additionally adhere to the specific QRTP requirements.

III. Status of FFPSA Implementation – July 1, 2021

A. Date of Applicability:

FFPSA becomes effective in Virginia on July 1, 2021. Generally speaking, all of the requirements apply only to youth in foster care placed in congregate care settings on or after that date. Youth already in a congregate care placement on July 1, 2021, are exempt and may continue, if eligible, to receive title IV-E support for the placement.[6] If a youth in placement on July 1, 2021 subsequently transfers to another congregate placement, the FFPSA requirements become applicable for that new placement.

B. For which children do the FFPSA Requirements apply?

During the *initial implementation* of FFPSA, children in foster care may continue to be placed in non-QRTP facilities. This allowance is because there are not sufficient designated QRTPs to ensure necessary placements. Local DSS and CSA programs are encouraged to prioritize the use of QRTP-designated facilities or one of the other specified settings.[7] Children in foster care placed in a non-QRTP setting are eligible for appropriate funding from CSA and Medicaid.[8] Title IV-E funds may not be used to support placements in non-QRTP designated facilities.

[5] As of July 1, 2021, there are limited facilities designated as one of the approved, non-QRTP congregate settings in Virginia. These programs will be authorized by VDSS.
[6] Effective July 1, 2021, title IV-E will not be a payment source for psychiatric residential treatment facilities (PRTF) regardless of their QRTP status. See Section III A of this document.
[7] For all QRTP designated placements, the FFPSA requirements (e.g., assessment by a qualified individual within 30 days of placement and judicial review and approval within 60 days of placement apply).
[8] For placements in a PRTF or TGH, the existing Medicaid IACCT process continues to be required to obtain Medicaid authorization and funding. The CSA FAPT and CPMT processes remain unchanged.

VDSS and the Office of Children's Services (OCS) have agreed that VDSS will implement a policy that children in foster care may not be placed in a non-QRTP congregate care setting, although they may be placed in one of the three other specified settings. A set time for this policy issuance has not yet been established and there may be exceptions to this policy.

C. What is the process for the "assessment by a qualified individual" necessary for an approved QRTP placement under FFPSA?

(Information available as of the issuance of this Guidance)

Local departments of social services will meet this requirement through a collaborative approach utilizing current practices of the Medicaid Independent Assessment, Certification, and Coordination Team (IACCT), Family Partnership Meetings (as defined in VDSS Guidance and Policy), and the Family Assessment and Planning Team (FAPT). This process will ensure alignment of the placement recommendation from the three sources and provide the final QRTP Assessment recommendation.

Local DSS agencies will utilize the current IACCT process (for all Medicaid eligible youth) to evaluate if a residential placement (PRTF or TGH) is needed. *The FAPT will review the IACCT recommendation and if a congregate care placement is determined necessary and appropriate, establish long and short-term goals for the child/youth (through the IFSP).* A Family Partnership Meeting will be held by the LDSS to engage the family and incorporate the family's voice and decision making regarding the long and short-term goals for the child, as well as any recommendations of the IACCT and the FAPT.

These three elements ensure compliance with the requirements of the FFPSA and this collaborative process will be utilized by the VDSS-designated qualified assessor to determine that a child's needs cannot be met in a family-based setting and that a QRTP is the best placement for the child consistent with their short and long-term goals.

The following graphic illustrates this process and it is the expectation that each of the components is completed within 21 days of the child's placement, in order to allow sufficient time to meet the 30-day requirement.

IV. Setting Specific Placement and Funding Considerations:

A. Psychiatric Residential Treatment Facilities (PRTF)

Independent of the FFPSA requirements, the Department of Medical Assistance Services (DMAS), with the concurrence of VDSS and OCS, has determined that *when a Medicaid member is in a PRTF, all costs (other than education) must be paid by Medicaid and cannot be "shared" with title IV-E*. As described in CSA Administrative Memorandum #20-11, *Upcoming Changes to Congregate Care Funding for Children in Foster Care*, effective with services provided on or after July 1, 2021, title IV-E must not support placements in PRTF settings. This change is summarized in Table A. Costs for PRTF placements are split between Medicaid (PRTF per diem components and additional Medicaid covered services) and CSA (education in the residential setting).[9,10]

Table A

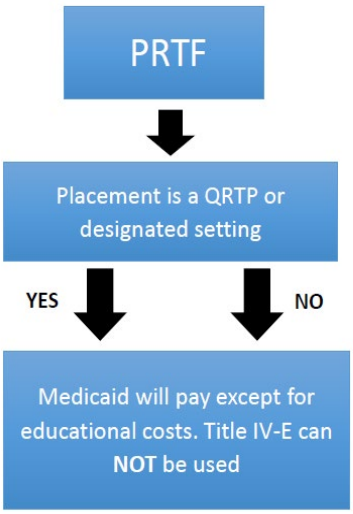
Service Category	Youth is a Medicaid Member and meets Medical Necessity Criteria for PRTF[11]	Funding Source
PRTF per diem components - Room and Board, Daily Supervision, some Therapeutic Services	**YES**	**Medicaid**
	NO	**CSA**
Educational Services	**YES**	**CSA**
	NO	**CSA**
Medicaid covered services in addition to the PRTF per diem, including EPSDT funded services	**YES**	**Medicaid**
	NO	**CSA**

This distribution of funding applies whether or not the PRTF is designated as a QRTP. However, the guidance about the preference for placing a child in a QRTP designated facility remains relevant.

The following graphic summarizes PRTF funding.

[9] The local Medicaid match collected on behalf of DMAS by OCS will increase with the elimination of title IV-E funding, as it is replaced by Medicaid.

[10] For purposes of coding in the Local Expenditure, Data and Reimbursement System (LEDRS), costs for title IV-E eligible children placed in a PRTF currently coded as Expenditure Code 1a, should continue to be coded as such to allow tracking of the impact of the shift from title IV-E to Medicaid funding.



If Medicaid determines that the child does not meet medical necessity criteria for the placement, the local DSS and CSA program should carefully consider whether a PRTF is the appropriate placement. This circumstance should rarely occur, and alternative placements should be sought whenever possible. Consultation with VDSS and DMAS is appropriate in such cases. However, if the qualified assessor and the FAPT decides the placement is appropriate, the placement is "acceptable" and CSA will be the payer.

1. What about children in foster care who do not have Medicaid?

Although this should be a rare occurrence (as children not eligible for Medicaid are not typically eligible for title IV-E), title IV-E can be used if the PRTF facility is a QRTP.

2. What about children placed in an out-of-state PRTF?

Prior to placement, the LDSS and the local CSA program should consult with VDSS Regional Permanency, title IV-E, and Interstate Compact for the Placement of Children (ICPC) consultants about whether the proposed placement is eligible for title IV-E funding through the LDSS.

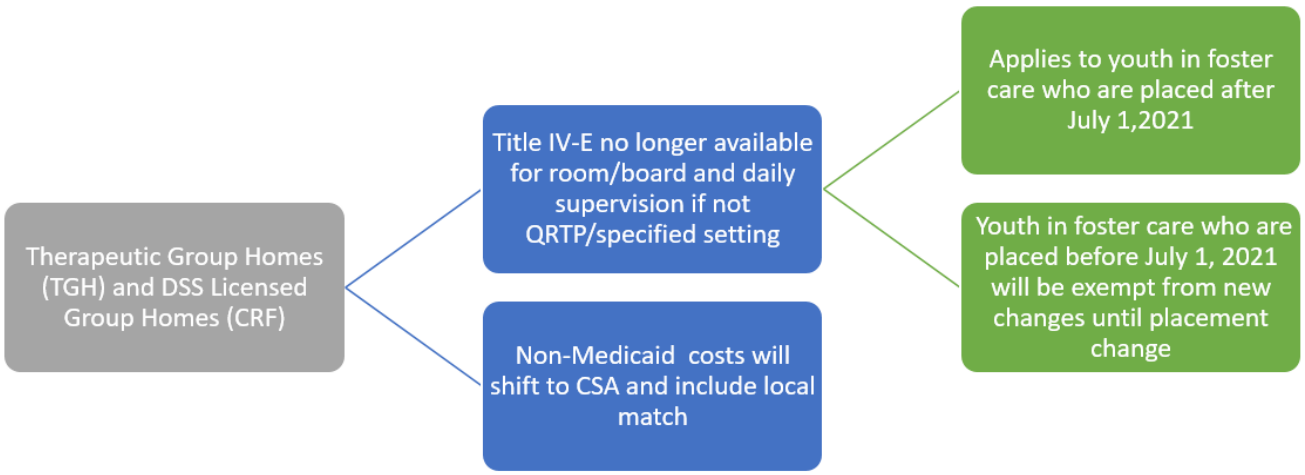
B. Therapeutic Group Homes (TGH)

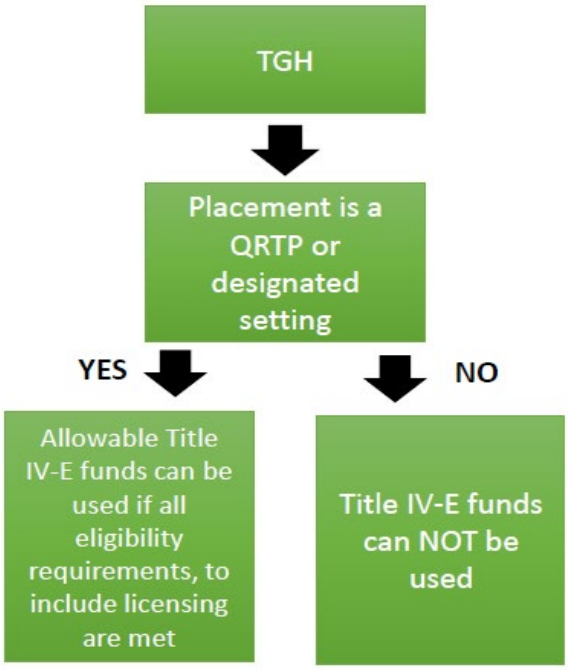
Under FFPSA requirements, effective with placements occurring on or after July 1, 2021, TGH facilities not designated as a QRTP are not eligible for title IV-E funding. Previously title IV-E funded group home services (room and board and daily supervision) will now become the CSA program's responsibility as these elements are not eligible for Medicaid reimbursement. Funding for TGH placements is seen in Table B.

TABLE B

Service Category	Youth is a Medicaid Member and meets Medical Necessity Criteria for a TGH	Funding Source
Medicaid TGH per diem components (i.e., Therapeutic Services)	**YES**	**Medicaid**
	NO	**CSA**
Room and Board, Daily Supervision (youth title IV-E eligible and QRTP designated facility)	**YES**	**Title IV-E**
	NO	**CSA**
Room and Board, Daily Supervision (youth not title IV-E eligible or not a QRTP designated facility)	**YES**	**CSA**
	NO	**CSA**

The following graphics illustrate title IV-E funding for a TGH (and CRF).





In addition to Medicaid (IACCT) authorization, the guidance about the preference for placing a child in a QRTP designated facility remains relevant, and the use of QRTP designated TGH programs reduces local CSA costs for title IV-E eligible children.

If Medicaid determines that the child does not meet medical necessity criteria for the placement, the local DSS and CSA program should carefully consider whether a TGH is the appropriate placement. This circumstance should rarely occur, and alternative placements should be sought whenever possible. Consultation with VDSS and DMAS is appropriate in such cases. However, if the qualified assessor and the FAPT decides the placement is appropriate, the placement is “acceptable” and title IV-E (if the youth is eligible and the TGH is a QRTP) and/or CSA will be the payer.

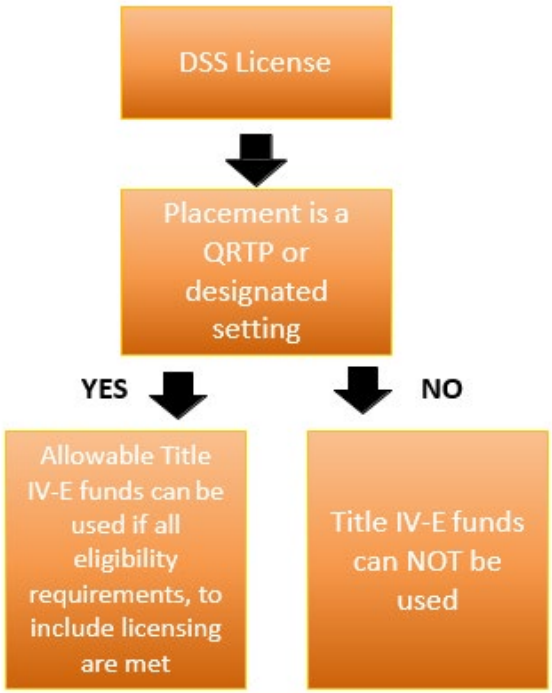
C. Children's Residential Facilities (CRF) (licensed by VDSS)

Under FFPSA requirements, effective with placements occurring on or after July 1, 2021, CRF facilities not designated as a QRTP are not eligible for title IV-E funding. Previously, title IV-E funded room and board and daily supervision in a children's residential facility. For non-QRTP facilities, the total cost of the placement is the CSA program's responsibility. Funding for CRF placements is seen in Table C.

TABLE C

Service Category	Funding Source
Room and Board, Daily Supervision (youth title IV-E eligible and QRTP designated facility)	**Title IV-E**
Room and Board, Daily Supervision (youth not title IV-E eligible and/or not a QRTP designated facility)	**CSA**
All other non-title IV-E covered services	**CSA**

The following graphic illustrates title IV-E funding for a CRF.



V. Meeting the FFPSA Congregate Care Procedural Requirements for all children in foster care placed in a QRTP

For all children in foster care placed in a QRTP setting on or after July 1, 2021, the LDSS is responsible for meeting the three procedural requirements (see Section I.B.) for children placed in a QRTP, regardless of their title IV-E status. Failure to complete these requirements resulting in a denial of title IV-E funding (if applicable) will not generally be payable by the CSA.[12]

[12] This only applies to group homes (TGH and CRF) as title IV-E will no longer be a payment source for PRTFs

An exception may be requested (per established VDSS procedure) if the reason for the failure is due to the timely completion of the required 60-day court hearing. In such instances, title IV-E can pay up to the 60th day and then no longer for the remainder of the placement.

If the reason for not meeting this requirement can be demonstrated to be beyond the control of the LDSS (i.e., due to delays imposed by the court), upon VDSS approval conveyed to OCS, CSA may pay for the denied title IV-E component of the placement. LDSS are encouraged to work with their courts and the Court Improvement Program in the Office of the Executive Secretary of the Supreme Court of Virginia to minimize instances resulting in a title IV-E denial under the FFPSA provisions.

VI. Resources

Family First Website (VDSS): https://familyfirstvirginia.com/foster_care/qrtp.html.

Family First Frequently Asked Questions about QRTPs (VDSS) document regarding QRTPs: (https://familyfirstvirginia.com/foster_care/qrtp_faq.html)

Listing of programs designated or being considered for designation as a QRTP: (https://familyfirstvirginia.com/foster_care/qrtp_applicants.html)

CSA Administrative Memorandum #20-11, *Upcoming Changes to Congregate Care Funding for Children in Foster Care*

VDSS Foster Care Guidance (pending update)

VDSS Title IV-Guidance (pending update)

QRTP Funding Guide

First 30 Days

- 30 day assessment complete (FPM, FAPT and IACCT) and recommended placement is a QRTP

Is assessment complete within 30 days?

- No → IV-E/CSA funds cannot be used for entirety of placement (STOP)
- Yes →

Within 60 Days of Placement

- LDSS Submits Documentation to court and requests 60 day court review hearing (hearing must take place within 60 days from start of placement)

Was review held within 60 days?

- No → IV-E/CSA Funds can only be used for first 60 days (STOP)
- Yes →

- Court review held within 60 days

Court reviews and determines
- Needs cannot be met in foster home
- QRTP most appropriate level of care
- Court approves placement

Determination confirms one of the above?

- No → IV-E funds can be used for up to 30 days from judicial determination date to transition Child (STOP)
- Yes →

Next 6-12 months

- Is child in QRTP
  - For 12 consecutive months?
  - For18 nonconsecutive months?
  - 6 consecutive or nonconsecutive months if child is under the age of 13?

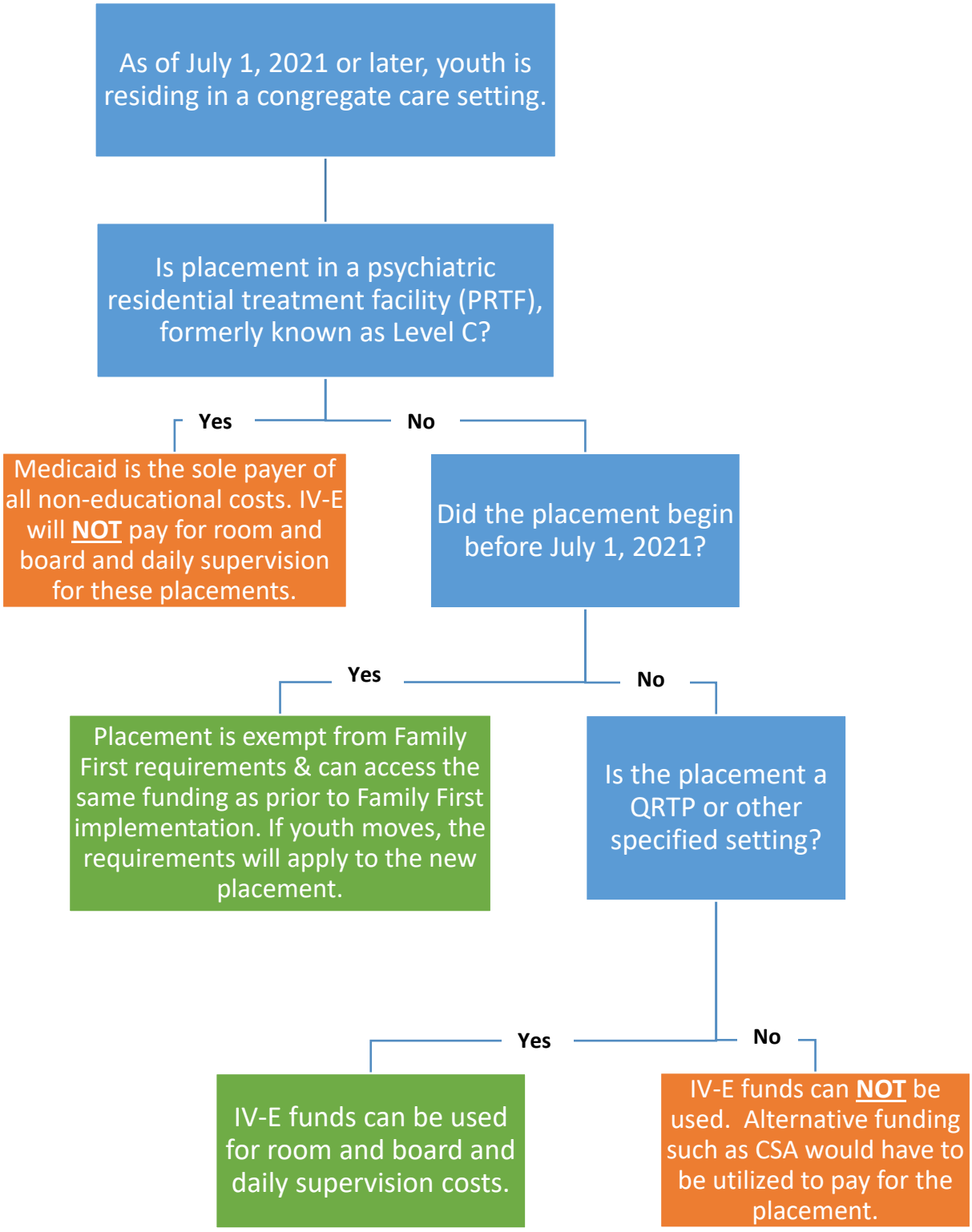
- No → Continue to monitor appropriateness of placement
- Yes →

- LDSS submits an approval request for the Commissioner to review to the practice consultant 45 days prior to the 6/12/18 month requirement

- Commissioner Review, QRTP placement

- No → IV-E/CSA funds can no longer be used (STOP)
- Yes → Approved for transitional 30 days to move child or continue ongoing placement

Family First Foster Care Funding Decision Tree



COMMONWEALTH of VIRGINIA

Scott Reiner, M.S.
Executive Director

OFFICE OF CHILDREN'S SERVICES
Administering the Children's Services Act

ADMINISTRATIVE MEMORANDUM #21-11

To: CPMT Chairs
CSA Coordinators
CSA Fiscal Agents

From: Scott Reiner, Executive Director

CC: Elizabeth Lee, Assistant Director, Division of Family Services, VDSS

Date: June 4, 2021

Subject: CSA Guidance Re: Implementation of Title IV-E Funded Foster Care Prevention Services through the Family First Prevention Services Act (FFPSA) – Effective July 1, 2021

After several years of work and unexpected delays, implementation of the Title IV-E funded foster care prevention services (evidence-based services) is finally upon us. Effective July 1, 2021, localities will be able to access three services designed to prevent a youth's entry into foster care – Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Parent-Child Interaction Therapy (PCIT). Much work has gone into planning this implementation, including the recently distributed standard model service contract template and information about the new DSS In-Home (foster care prevention) model.

The guidance document attached to this Administrative Memorandum describes the interactions between the LDSS and the local CSA program in implementing these new services. Many partners, at both the state and local levels, have contributed to this guidance. I hope you find that it supports the system of care approach at the core of the CSA. The primary author at OCS is Carol Wilson.

Local discussions about how to best implement this guidance are necessary and many of you have already begun this process. OCS has scheduled a webinar on June 16 at 2:00 P.M. to provide any needed clarification and to answer questions you may have.

We hope you share our excitement as Virginia moves closer to our vision of effective prevention services to serve children and families before the need for them to enter DSS custody emerges. The new federal funds under FFPSA provide eligible families with access to these high-quality services at no cost to your locality.

Please review the attached document carefully and let us know if you have any specific questions.

Guidance for Local Children's Services Act (CSA) Programs on the Virginia Department of Social Services (VDSS) Implementation of In-Home Services and the Family First Prevention Services Act (FFPSA)

Effective July 1, 2021

I. Introduction and Purpose

The document guides Community Policy and Management Teams (CPMTs), Family Assessment and Planning Teams (FAPTs), and CSA Coordinators, working with local departments of social services (LDSS), in implementing the new VDSS foster care prevention practice model (referred to as "In-Home Services.")

As a part of In-Home Services, DSS is implementing the federal Family First Prevention Services Act (referred to in this document as FFPSA or "Family First"). FFPSA allows utilization of title IV-E funds to support specific evidence-based services to prevent foster care placement, creating a new funding stream for these services to families through the new In-Home model.

Implementation of the prevention In-Home model and Family First are interrelated. Both focus on the prevention of foster care placement. Consequently, the new In-Home model incorporates Family First requirements for accessing title IV-E funding for prevention services.

This guidance deals specifically with eligibility for title IV-E prevention services, not eligibility for title IV-E foster care. Eligibility for title IV-E prevention services under FFPSA **is not** based on the family's income, deprivation factors, or court documentation as needed for title IV-E foster care eligibility. Neither the implementation of Family First or the In-Home model changes the eligibility requirements for the title IV-E foster care or the process of how that eligibility is determined.

However, Family First does place new requirements on using title IV-E funds for youth in foster care in congregate care placements. Separate guidance for CSA Coordinators and local teams using "Qualified Residential Treatment Programs" (QRTPs) is available.

A. What is the Family First Prevention Services Act (FFPSA)?

The FFPSA is comprehensive federal legislation intended to support evidence-based prevention services to families whose children are otherwise likely to be placed in foster care. By bolstering the provision of community and evidence-based interventions, the expectation is that fewer children enter foster care. Family First allows the use of title IV-E funds, which are 50% federal and 50% state, to achieve this goal.

FFPSA may fund only certain evidence-based practices in mental health, substance use disorders and in-home parenting skills. The federal government has established a

clearinghouse which lists and provides information about evidence-based services that utilize title IV-E funds through the FFPSA. States must also notify the federal government which services they plan to implement through a title IV-E prevention plan. The VDSS Prevention Plan includes Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), and Parent-Child Interaction Therapy (PCIT). These are the only prevention services funded by title IV-E when FFPSA is implemented in Virginia on July 1, 2021.

For more information on the overall implementation of FFPSA in Virginia, please see https://familyfirstvirginia.com/

II. Overview and Components of the VDSS In-Home Model

A. Why is an In-Home Model being Implemented?

The VDSS federal Child and Family Services Review (CFSR) noted areas needing improvement in local DSS practice, particularly the lack of service provision to families who had identified needs. The primary reason identified by a survey of local DSS staff was difficulty in engaging families in the receipt of services.

To address the weaknesses identified in the CFSR, VDSS developed a Program Improvement Plan (PIP) with input from local and state DSS and community partners. As family engagement was determined to be an issue, efforts to develop a more family-focused solution resulted in the reorganization and implementation of the new In-Home model.

B. Eligibility for Foster Care Prevention Services

All (formerly called) LDSS Child Protective Services (CPS) Ongoing and Foster Care Prevention cases are served through the In-Home model. The local DSS opens cases based on a high or very high classification on the Structured Decision Making (SDM) Risk Assessment. The In-Home model also includes "court cases" (e.g., a Child in Need of Services for whom the court has ordered LDSS to provide foster care prevention services).

These children and families are determined to be eligible for foster care prevention services by completing the title IV-E Candidacy Form, which documents the decision that the child is a "Candidate for Foster Care."

> *A "Candidate for Foster Care" is defined as a child identified in a prevention plan as being at imminent risk of entering foster care but who can remain safely in the child's home or in a kinship placement as long as services or programs that are necessary to prevent the entry of the child into foster care are provided. The term includes a child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement."*

"Imminent Risk of Foster Care" is defined in Virginia "as a child and family's circumstances demand that a defined case plan is put into place within 30 days that identifies interventions, services and /or supports and absent these interventions, services and/or supports, foster care placement is the planned arrangement for the child."

Note: These definitions are on the DSS Family First website

The LDSS Family Services Specialist (FSS) completes the "Candidate for Foster Care" Form.

Children and their families who meet these foster care prevention criteria established by VDSS are eligible for CSA and sum sufficient services under CSA (COV §§ 63.2-905, 2.2-5211.B3., 2.2-5211.C., and 2.2-5212.4.). It is important to note that these children and families (CPS Ongoing or Foster Care Prevention) are already eligible for CSA services under the eligibility categories in the cited statutes.

The designation as a "Candidate for Foster Care" makes the child and family eligible for foster care prevention, no matter whether any specific funding source, including CSA, is accessed. However, this designation assures a child and family's eligibility for any of the evidence-based services offered in Virginia through FFPSA beginning July 1, 2021. As noted earlier, these three services are Multi-Systemic Therapy (MST), Family Functional Therapy (FFT), and Parent-Child Interaction Therapy (PCIT). Additional services are likely to be added to this list in the coming years.

C. Service Provision

1. What is Multi-Systemic Therapy?

Multi-systemic Therapy (MST) is an intensive treatment delivered in multiple settings. MST aims to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and illicit substance use in 12 – 17-year-old youth. MST addresses core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, family, school, peers, and community. Intervention strategies are individualized to address the identified drivers of behavior. More information about MST is found at: https://www.mstservices.com/.

2. What is Functional Family Therapy (FFT)?

Functional Family Therapy (FFT) is a short-term, family-based intervention program for youth and their families. FFT aims to address risk and protective factors that impact the adaptive development of 11 to 18-year-old youth referred for behavioral or emotional problems. Family discord is also a target. More information about FFT is found at: https://www.fftllc.com/.

3. What is Parent-Child Interaction Therapy?

Parent-Child Interaction Therapy (PCIT) provides coaching to parents by a therapist trained in behavior-management and relationship skills. PCIT is a program for two to seven-year-old children and their parents or caregiver to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the parent-child relationship. During weekly sessions, therapists coach caregivers in child-centered play, communication, increasing child compliance, and problem-solving. More information about PCIT is found at: http://www.pcit.org/.

Additional information on all three evidence-based practices is found at: https://familyfirstvirginia.com/

4. Other Prevention Services

Provision of services to children and families through the "In-Home" model is not limited to identified evidence-based services funded by title IV-E through FFPSA. Families may receive a wide range of prevention services. These include but are not limited to: mental health interventions; substance use disorder treatment; concrete supports (e.g., financial assistance with utilities, housing, transportation); or other community-based services (e.g., mentoring, individual or family support services or interventions). As is current practice, these services are funded from the appropriate source such as Medicaid, CSA, Community Services Board (CSB) Mental Health Initiative, DSS Promoting Safe and Stable Families (PSSF), and other designated DSS funding. FFPSA does not restrict the provision of other foster care prevention services. Instead, it simply adds a new funding source for the evidence-based services.

D. Assessment with the Child and Adolescent Needs and Strengths (CANS)

The implementation of FFPSA requires the use of an evidence-based functional assessment, such as the CANS. The CANS allows LDSS professionals to improve identification of a family's needs and strengths, service planning and provision, and ongoing review of the services' effectiveness in foster care prevention cases.

As the CANS is the mandatory uniform assessment instrument for CSA, a structure exists to support its use with In-Home cases. Currently, the CANS is administered to children and families receiving foster care prevention services reviewed by FAPT for possible CSA funding. The online CANS software system (CANVaS) is utilized for assessments of all foster care prevention cases (i.e., In-Home cases), even if CSA funding is not sought or provided. However, the system needs to have a way to identify which assessments are "CSA" and those done for In-Home cases. The rater identifies In-Home cases at the individual assessment level.

VDSS requires the administration of the CANS every 90 days for children and caregivers served through the In-Home model to assure the ongoing assessment of the family's needs and

strengths and evaluate progress towards meeting the goals on the prevention plan. Efforts should be made to avoid duplication of assessments. For example, a CANS assessment completed in the past 30 days for an In-Home case may be accepted by CSA if the child and family are referred to FAPT.

Local DSS agencies are encouraged to identify additional CANVaS Local Administrators (also known as DSU/RAs) to assist with case manager account creation, monitoring of completed CANS and access to the system reports for DSS, including In-Home cases.

Newly identified LDSS Local Administrators should review the guide describing the primary responsibilities of Local Administrators found on the OCS website in the CANS folder (www.csa.virginia.gov/CANS) or the "Documents" folder in CANVaS. There are no changes to the process for creating Local Administrators. The "Request to Create or Reactivate a Local Administrator Account" form must be completed, signed by the user and the user's supervisor, and sent to the attention of Carol Wilson in the Office of Children's Services (carol.wilson@csa.virginia.gov). A copy of the user's CANS certification must be attached.

The goal of the implementation of CANS is not only to meet a federal requirement for those cases that might require FFPSA funding. The intent is for the local DSS and community to have a commonly used and recognized functional assessment to help local foster care prevention staff carry out their job responsibilities. The use of the CANS acknowledges that the first step in providing human services is an assessment that allows a community, agency, and family members to identify strengths and needs and determine how to move forward in service plan development and implementation. Reassessments evaluate the progress towards those goals and allow the team to assess if other services may be more effective.

III. The Multi-Disciplinary Approach

A. The intent of MDT review

Recognizing that children and families are the community's shared responsibility, not any single agency's, VDSS requires multi-disciplinary teams to support the new In-Home service delivery model. MDTs are frequently used in children's services, particularly since the advent of the System of Care philosophy and principles in the 1980s.

Until this shift in services to children and families, service provision was primarily determined by the family's presenting problem and the agency to which they were referred. This practice resulted in inefficient and ineffective fragmentation and duplication of services provided through what are known as "silos," meaning agencies operated independently of each other.

The System of Care philosophy introduced the idea that families are ideally viewed holistically, not parceled out into separate program areas to address different issues. Families who come to the attention of agencies may have complex needs requiring a multi-disciplinary approach. The

focus on seeing the child and family as part of the community emerged. No one agency is responsible for working with the child and family; instead, the expertise and resources of all of the community's agencies should be brought to bear.

Multi-disciplinary review and coordination of services gather the community's strengths and resources to address the family's needs. The goal is to integrate the family into successful functioning in the community, not resolve an immediate crisis and "close the case." All community partners have the responsibility to provide the support the family needs. Without such a community-wide approach, the families and children in foster care prevention continue to be seen as "DSS cases." They may be likely to cycle back to DSS intervention through generations, or as Court Services Unit (CSU) cases with youth who move from juvenile status offenses, to delinquency and then adult crime.

B. Multi-disciplinary Review Teams and the In-Home Model

Recognizing the inherent value of MDTs, VDSS requires a multi-disciplinary review for all In-Home cases to access title IV-E prevention funds for any of the evidence-based services funded through the FFPSA. As currently required by statute, FAPT review is necessary for In-Home cases that seek CSA funding for foster care prevention services.

To meet the MDT requirement for local DSS wishing to access IV-E funded evidence-based prevention services, local governments may choose from the following options:

A. *Family Assessment and Planning Team (Comprehensive)*

A locality may opt to have In-Home cases reviewed by the regular FAPT, following the current local process for multi-disciplinary review and coordination of funding and services through CSA.

1. Family Assessment and Planning Team (Consultative)

As an alternative, a locality may wish to use the model of a "consultative" FAPT with reduced expectations and requirements. For example, the VDSS prevention plan may serve as the service plan. **The purpose of this team review is not to determine eligibility for CSA or provide funding through CSA but to provide the multi-disciplinary perspective regarding the use of an Evidence Based Practice (EBP).** As this is not a FAPT determining the CSA eligibility of youth or use of CSA funds, reduced documentation is permissible. This documentation may include a referral cover sheet, the VDSS prevention plan, which may substitute for the Individual and Family Services Plan (IFSP), and a current CANS. The FSS verbally provides the consultative FAPT with summary information.

The following chart outlines and compares the expectations of a Consultative and Comprehensive FAPT.

Activity	IN-HOME CONSULTATIVE FAPT	COMPREHENSIVE FAPT (likely to, or needing CSA funding)
Eligibility	Children and families being served through "In-Home" practice standards as established by the Virginia Department of Social Services (VDSS) who meet the criteria established for "imminent risk" as defined by VDSS. These children and families are eligible (and sum-sufficient) for CSA as they are receiving foster care prevention services in accordance with COV §63.2-905 (Foster Care Services).	
Referral Process	**Services not funded by CSA may begin before FAPT review.** While only essential referral information is encouraged, localities should decide what information is needed to offer a helpful consultation. The In-Home worker could provide a simplified referral cover sheet, the proposed prevention plan, and an oral description of the case (e.g., why the family came to the attention of DSS, why an in-home case is opened, needs and strengths as identified on the CANS, what services or supports are in place or DSS plans to put in place, etc.) VDSS Prevention plans may substitute for IFSPs.	If a case never requires CSA funds, a Comprehensive FAPT is unnecessary. If at the "In-Home" (Consultative) FAPT it is determined that CSA funds are needed, local practice determines what information from the "In-Home FAPT" may be used for referral to a Comprehensive FAPT to eliminate duplicative information/ paperwork. If known at the outset that CSA funds are needed or likely to be needed, the case should go directly to Comprehensive FAPT using current local CSA processes (no Consultative FAPT held).
CANS Requirements	Every 90 days as determined by VDSS. CANVaS is modified to flag In-Home cases when no CSA funding is accessed.	No changes to State Executive Council (SEC) Policy or current local practice. A new CANS is not needed for a Comprehensive FAPT if a CANS was completed in the previous 30 days.
FAPT Roles/Activities	FAPT's role is one of consultation, coordination, service recommendations, and periodic case reviews.	No changes to current practice.
Time Frames for Action by FAPT	VDSS policy requires a Prevention Plan and a CANS done within the first 30 days. Services funded by FFPSA may begin before FAPT review.	Cases should be reviewed promptly. Local CPMTs are required by Code to have policies allowing immediate access to funds for placement and services. If emergency CSA funding is needed, the case comes to Comprehensive FAPT with the usual 14-day requirement for FAPT review of emergency placements/services.
Service Plan Requirements	In-Home Prevention Plan to include a parental signature.	In-Home Prevention Plan to include a parental signature.
Audit Requirements	Title IV-E funding is reviewed/audited by VDSS.	No change to current practice. CSA funds are subject to OCS audit.

Activity	IN-HOME CONSULTATIVE FAPT	COMPREHENSIVE FAPT (likely to, or needing CSA funding)
CPMT Role/Activities	Current role of policy and practice oversight/coordination. Broad system oversight/CQI at the local level. Encourage review of data in light of new structure and practices (outcomes, increased referrals for/use of CSA funds for FC prevention, implementation of evidence-based practices through FFPSA, etc.). Discuss how to integrate EBPs across all child-serving systems. Develop policy re: the referral and operation of the Consultative FAPT. CPMT authorization of non-CSA expenditures is not required.	Current role of policy and practice oversight/coordination. Broad system oversight/CQI at the local level. Encourage review of data in light of new structure and practices (outcomes, increased referrals for/use of CSA funds for FC prevention, implementation of evidence-based practices through FFPSA, etc.). Discuss how to integrate EBPs across all child-serving systems. Develop policy re: the referral and operation of the Consultative FAPT. CPMT authorization of CSA expenditures.
Data Requirements	CANVaS captures assessment data from In-Home cases. These cases are entered into LEDRS as title IV-E/FFPSA. Required data from EBPs is tracked by FFPSA evaluators and included in the service provider contracts.	No changes to current state practice.
Case Review Requirements (UR)	As determined by VDSS.	No changes to the current state or local practice.
Use of Approved Alternate MDT for In-Home Cases	May be appropriate. MDTs may have specialized focus and slightly different requirements. MDTs require VDSS and SEC approval.	No changes to current local practice. MDTs require SEC approval.
Service Contracting, Invoicing, and Payment	VDSS reimburses the LDSS through a budget line in LASER. VDSS (along with OCS) issued an EBP "model contract template" for either local CSA or LDSS that includes standard service prices. The locality determines how contracting, invoicing, and payment for services occur.	Current contracting, invoicing, and payment practices continue.
Parental Co-Payment	No co-pay required unless the funding source used requires a co-pay.	No changes to current state and local co-payment policies.
Local Policy Development	Localities develop minimal standards for referral to Consultative FAPT and include this in local policy. The policy should describe how FAPT is used as a consultative multi-disciplinary team.	Local CPMTs are required by Code to have policies that allow immediate access to funds for placement and services. If emergency CSA funding is needed, the case comes directly to the Comprehensive FAPT with the usual 14-day requirement for review. The locality develops policy describing how In-Home cases previously

Activity	IN-HOME CONSULTATIVE FAPT	COMPREHENSIVE FAPT (likely to, or needing CSA funding)
		heard by Consultative FAPT are referred to Comprehensive FAPT.

a. Referral from a Consultative FAPT to a Comprehensive CSA FAPT

The consultative FAPT may, during its review, determine that additional services are needed for the child and family. If so, the consultative FAPT "refers" the case to a (Comprehensive) FAPT. Each locality must develop a policy regarding how these referrals are made and the associated expectations. Once the case is referred to the FAPT process for possible CSA funding, it is treated like any other case coming to FAPT. The CPMT must approve CSA funding.

2. Approved Alternate Multi-Disciplinary Team (MDT)

The third option for localities is to request an alternative MDT to review only In-Home cases seeking access to a title IV-E funded EBP. The Code of Virginia provides for such alternate multi-disciplinary teams (MDTs), established per COV §2.2-2648 (14) and State Executive for Children's Services Policy 3.2.2.

Creation and implementation of an approved alternate MDT allows a local government to design a team which best fits local needs. Decisions such as which agencies would serve on the team, if other parties will be represented on the team (e.g., private providers), whether it is a standing or ad hoc group and whether there is a financial limit (e.g., only hearing cases with a potential cost of up to a certain amount) are determined by the CPMT, which then submits the request to VDSS and then OCS to review for SEC approval. If an alternate MDT is established and approved, it may substitute for a Comprehensive FAPT. A request for CSA funding may be submitted directly from an alternate MDT to the CPMT.

The alternate MDT may not be the DSS Family Partnership Meeting, held at specific and critical decision points. The alternative MDT may be a "Child and Family Team," with the inclusion of the requirements outlined in this document. To become an approved MDT, the Child and Family Team must meet the approval process for an alternate MDT. The partner agency representatives are determined based on the specific needs of the child and family as determined by the CANS and the LDSS. For example, the child's CSB therapist may serve as the CSB representative. If no agency other than LDSS is currently involved with the family, the LDSS, using the assessment should determine which other agency or agencies should participate. Other parties or providers may participate as deemed necessary to the service planning process. The locality must take the following steps to establish an alternate MDT to implement the FFPSA:

a. The Director, VDSS Division of Family Services, or designee, must approve a request from the CPMT and LDSS Director to establish a collaborative, alternative MDT for

accessing title IV-E prevention services funding. Upon approval from VDSS, the CPMT, as provided for in COV §2.2-2648 (14), shall submit the request to the Office of Children's Services (OCS) for presentation to the State Executive Council for Children's Services (SEC), following OCS procedures. The SEC shall review and approve the request, as appropriate. See also: COV §2.2-5209.

b. Requests for such approval shall be in writing and made available for review by the VDSS, OCS, and the SEC.
c. The CPMT and LDSS shall develop and approve written policies governing the membership and operation of the MDT. The CPMT and LDSS shall make these policies available for review to VDSS and OCS before referral to the SEC for consideration. The policies must specify:
    i. The purpose of the MDT, including the types of cases/circumstances that will be considered.
    ii. How the MDT procedures and practices align and integrate with those of the CPMT's member agencies.
    iii. Whether the MDT shall be a standing team that meets regularly or if it will operate on an ad hoc basis. If on an ad hoc basis, under what circumstances will the MDT be convened and through what procedure. Examples of regular, standing MDTs include teams for children in residential care, truancy cases, or In-Home Services/foster care prevention.
    iv. The minimum number of agency representatives constituting the MDT (from among the FAPT-required member agencies). This specification shall identify the agencies represented on the MDT and processes for soliciting additional input from other agencies, as needed.
    v. How the MDT includes family engagement practices and be family-driven.
    vi. The process through which funding approval requests will be submitted directly from the MDT to the CPMT for any CSA-funded expenditures and from the MDT to the LDSS for Family First title IV-E prevention expenditures.
    vii. The process through which title IV-E prevention expenditures will be submitted through the Local Expenditure, Data and Reimbursement System (LEDRS) T4E (Title IV-E) file.
    viii. How the MDT will utilize: interagency collaboration and family involvement to assess the family's strengths and needs; assessment tools to identify appropriate services; monitor service delivery and progress towards treatment goals; and establish ongoing community support for the family for when the child welfare case is closed.
    ix. How the MDT process and outcomes are regularly documented and reviewed.

If the option of an approved alternate MDT is chosen, the locality needs to establish this process and include it in its written policy.

C. Local Procedures Regarding the Multidisciplinary Review

Each local DSS, CSA, including FAPT and CPMT, and agency partners must work collaboratively to decide how to incorporate the requirement for multi-disciplinary review of In-Home cases seeking FFPSA funding. One of the three described above options must be chosen. Local policy will reflect the expected flow of In-Home cases seeking title IV-E funding for EBP services from LDSS to either the comprehensive FAPT, the consultative FAPT, or an approved MDT.

IV. Role of the CPMT

Consistent with the statutory expectations of the CSA, the CPMT provides oversight and leadership in coordinating the community's response to all identified children and families, including those receiving title IV-E funded foster care prevention services. With the introduction of the FFPSA, this role includes maintaining awareness of the utilization and impact of the new In-Home prevention practices (e.g., increased/decreased referrals for the use of CSA funds for foster care prevention, outcomes, and the integration of evidence-based practices across all child-serving agencies)

There are no changes regarding statutory expectations and the roles of FAPT and CPMT in the implementation of CSA, including eligibility and funding. FAPT may provide a multi-disciplinary review for any referred child and family in the community, even if CSA funds are not needed.

V. Contracts

Each locality determines how contracting, invoicing, and payment for the title IV-E funded evidence-based services are managed. Localities may use existing CSA contracting, purchasing, and invoice processing systems or develop FFPSA-specific processes. As Family First funding is directed from VDSS to the local DSS, LDSS agencies use current financial processes to obtain reimbursement through the VDSS LASER system. However, Family First requires specific client-specific data not captured in LASER. Following VDSS guidance, this information is to be submitted through the title IV-E capabilities of the CSA LEDRS system.

OCS Administrative Memo #21-08 provides a model contract template for the evidence-based services which may be purchased either through title IV-E or CSA.

VI. Use of the Local Expenditure, Data, and Reimbursement System (LEDRS)

Effective July 1, 2021, the LDSS shall submit all expenditures of title IV-E payments for Foster Care and In-Home Prevention Services through the Local Expenditure, Data, and Reimbursement System (LEDRS) T4E (title IV-E) file. The VDSS Division of Family Services and the Office of Children's Services (OCS) worked collaboratively to update the current LEDRS

system to accommodate the additional required federal reporting for the Family First Prevention Service Act (Family First).

The LEDRS T4E file submission with the appropriate filename must be submitted quarterly based on the schedule below.

Date Range	Expenditure File Report Due	Filename
July 1 - Sept 30	31-Oct	T4E_*FIPS*_Q_*YYYY*_1_1.txt
Oct 1 - Dec 31	31-Jan	T4E_*FIPS*_Q_*YYYY*_2_1.txt
Jan 1 - Mar 31	30-Apr	T4E_*FIPS*_Q_*YYYY*_3_1.txt
Apr 1 - Jun 30	31-Jul	T4E_*FIPS*_Q_*YYYY*_4_1.txt

FIPS = County FIPS Code (no padding of zeros)
YYYY = 4 digit calendar year of the file submission

The submission through LEDRS of expenditures of title IV-E funds for both Foster Care and In-Home Prevention Services allows VDSS to enhance their quality assurance and accountability reviews of title IV-E.

VII. DSS State and Federal Reporting

LDSS shall submit all required state and federal reporting for all title IV-E prevention services funding. The following information shall be submitted through a combination of methods, including LEDRS, LASER, and the Child Welfare Information System:

A. Client-Level Information and Spending

	Child Welfare Information System (OASIS/Compass Mobile)	LEDRS
Client's Full Name	X	X
Date of Birth	X	X
Client ID	X	X
Child's Case ID	X	
Identified Referral Reason	X	
Service Name	X	X
Service Start Date	X	X

Service End Date (projected end date if service is still ongoing)	X	X
Total Estimated Cost of Services		X
Total Amount Billed For Service		X

B. Budget Line 835 IV-E Prevention Services Information (LASER)

1. Total amount allocated
2. Actual use of funds
3. Projected use of funds

COMMONWEALTH of VIRGINIA

Scott Reiner, M.S.
Executive Director

OFFICE OF CHILDREN'S SERVICES
Administering the Children's Services Act

Administrative Memorandum #21-12

To: CPMT Chairs
CSA Coordinators

From: Scott Reiner, Executive Director

Date: June 7, 2021

Subject: Annual CSA Service Gap Survey

Section 2.2-5211.1.2 of the Code of Virginia requires that: "The community policy and management team shall report annually to the Office of Children's Services on the gaps in services needed to keep children in the local community and any barriers to the development of those services." This requirement led to the implementation of the annual CSA Service Gap Survey, which has been in place since 2007. The Survey can also serve as a resource to local CSA programs in meeting the language of §2.2-5206.4 that each CPMT shall: "Coordinate long-range, community-wide planning that ensures the development of resources and services needed by children and families in its community …"

Thank you for your cooperation in completing the 2021 Service Gap Survey. The results are now tabulated and summarized. They are included with the Memo and are also available on the OCS website. We hope this information will be helpful to your localities in meeting the needs of children and families and fulfilling your planning responsibilities.

Please direct any technical questions about the Service Gap Survey to Howard Sanderson, CSA Senior Research Analyst at howard.sanderson@dss.virginia.gov.

cc: Howard Sanderson

Attachment: FY2021 Service Gap Survey.pdf

Office of Children's Services
Empowering communities to serve youth

Results of the FY2021 CSA Service Gap Survey

Background of the CSA Service Gap Survey

- One primary responsibility of the Community Policy and Management Team (CPMT) is to coordinate long range, community-wide planning to develop resources and services needed by children and families in the community (§2.2-5206).

- The 2006 Virginia General Assembly amended the Code of Virginia to further specify this requirement. On an annual basis, the CPMT shall report to the Office of Children's Services (OCS) on gaps and barriers in services needed to keep children in the local community (§2.2-5211.1.2).

- This report marks the 13th year that data has been collected by OCS on service gaps, barriers to filling these gaps, and local efforts to overcome the barriers.

Methodology

- Emails sent to CPMT Chairs and CSA Coordinators with link to automated Survey Monkey survey on February 24, 2021
- Survey closed on May 19, 2021
- One submission permitted per locality (some localities filed jointly under one CPMT)
- 107 response out of 123 possible - 87% response rate
- Utilized VDSS regions to group localities

Service Groupings

Residential Services
- ☐ Short-term Diagnostic
- ☐ Group Home
- ☐ Residential Treatment

Crisis Services
- ☐ Crisis Intervention/Stabilization
- ☐ Acute Psychiatric Hospitalization

Family Support Services
- ☐ Family Partnership Facilitation
- ☐ Respite
- ☐ Intensive Care Coordination (ICC)
- ☐ Family Support Partner
- ☐ Child Mentoring Parent Coaching

Community-Based Behavioral Health Services
- ☐ Assessment
- ☐ Group Therapy
- ☐ Family Therapy
- ☐ Intensive In-Home
- ☐ Therapeutic Day Treatment
- ☐ Case Management
- ☐ Medication Management
- ☐ Applied Behavior Analysis
- ☐ Trauma Focused/Informed Services

Educational Services
- ☐ Private Day School
- ☐ Residential School
- ☐ School-based Mental Health Services

Evidence-based Behavioral Health Services
- ☐ Multi-systemic Therapy
- ☐ Functional Family Therapy
- ☐ Parent Child Interaction Therapy
- ☐ Cognitive Behavioral Therapy
- ☐ Motivational Interviewing

Foster Care Services
- ☐ Family Foster Care Homes
- ☐ Therapeutic Foster Care Homes
- ☐ Independent Living Services

Other Services
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Populations and Age Groups

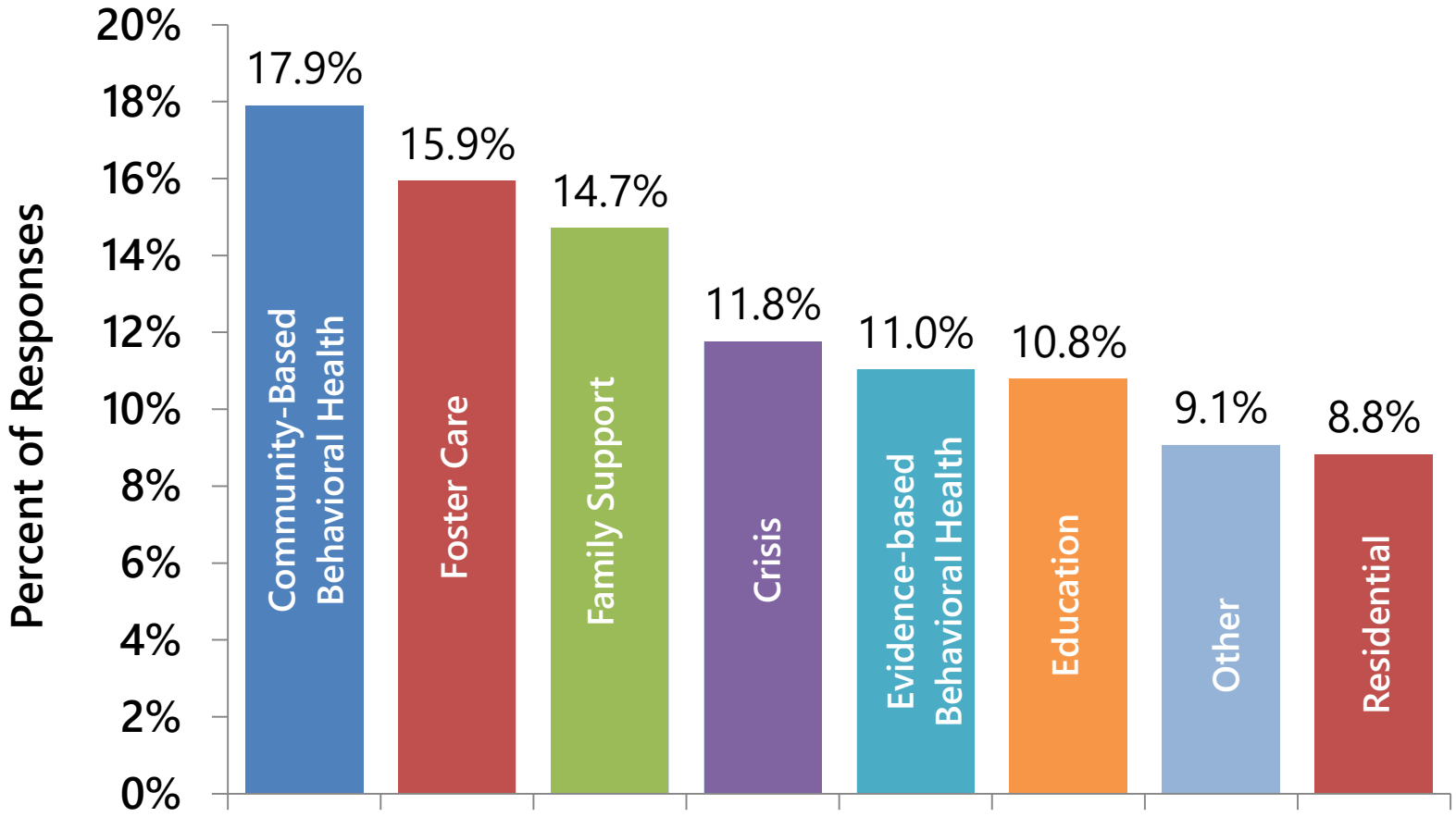
Populations

☐ Autism
☐ Intellectual Disability/Developmental Disability
☐ Potentially Disrupting or Disrupted Foster Care Placements
☐ Potentially Disrupting or Disrupted Adoptions
☐ Sex Offending/Sexually Reactive Behaviors
☐ Youth with Multiple Mental Health Diagnoses
☐ Youth involved with the Juvenile Justice System
☐ Substance Abuse
☐ Other:

Age Groups

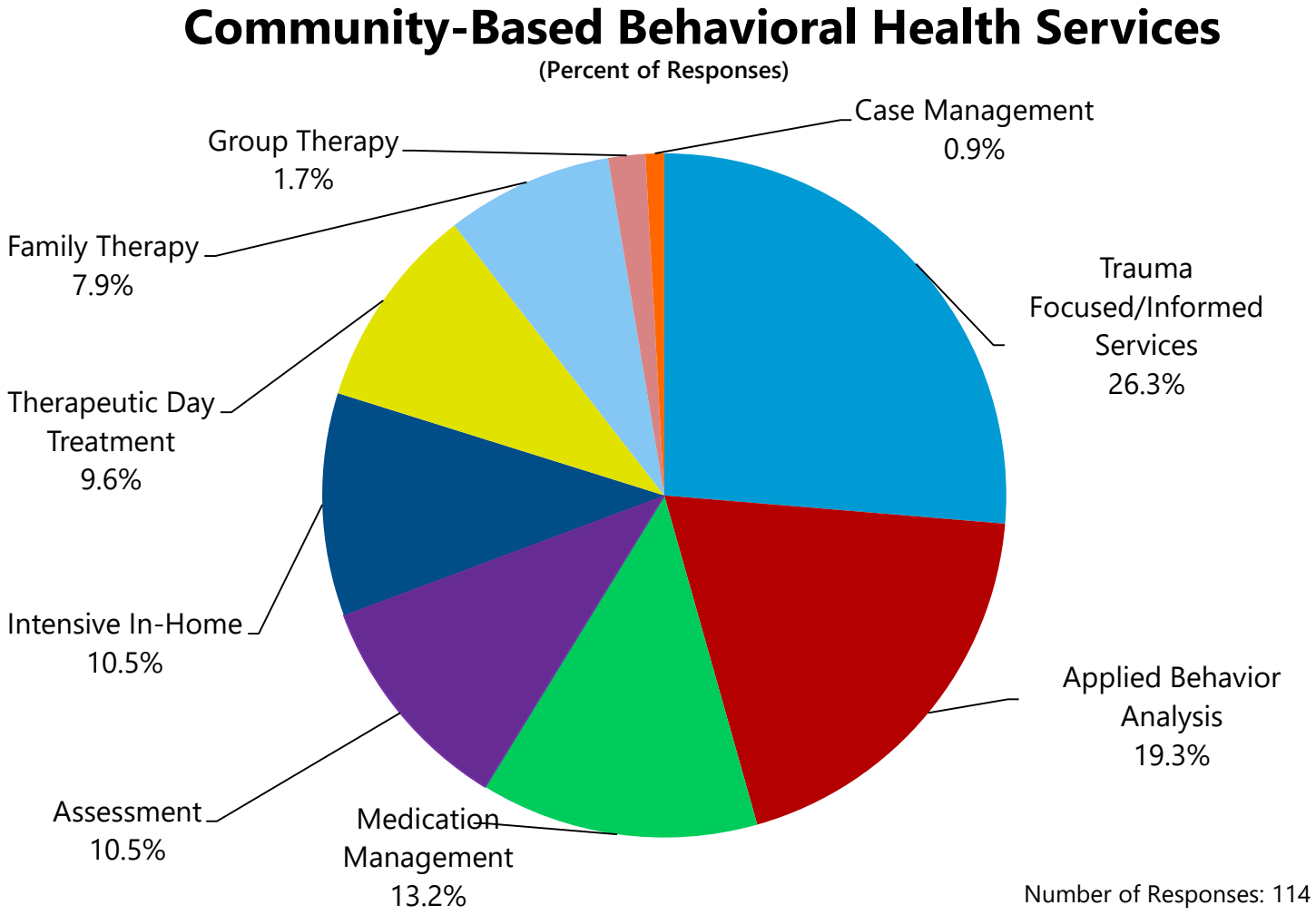
☐ Pre-School Age (0-5)
☐ Elementary School Age (6-10)
☐ Middle School Age (11-13)
☐ High School Age (14-18)
☐ Transition Age (19-21)

Gaps Grouped by Type of Service: Statewide



Number of Responses: 408

Service Gaps: Statewide

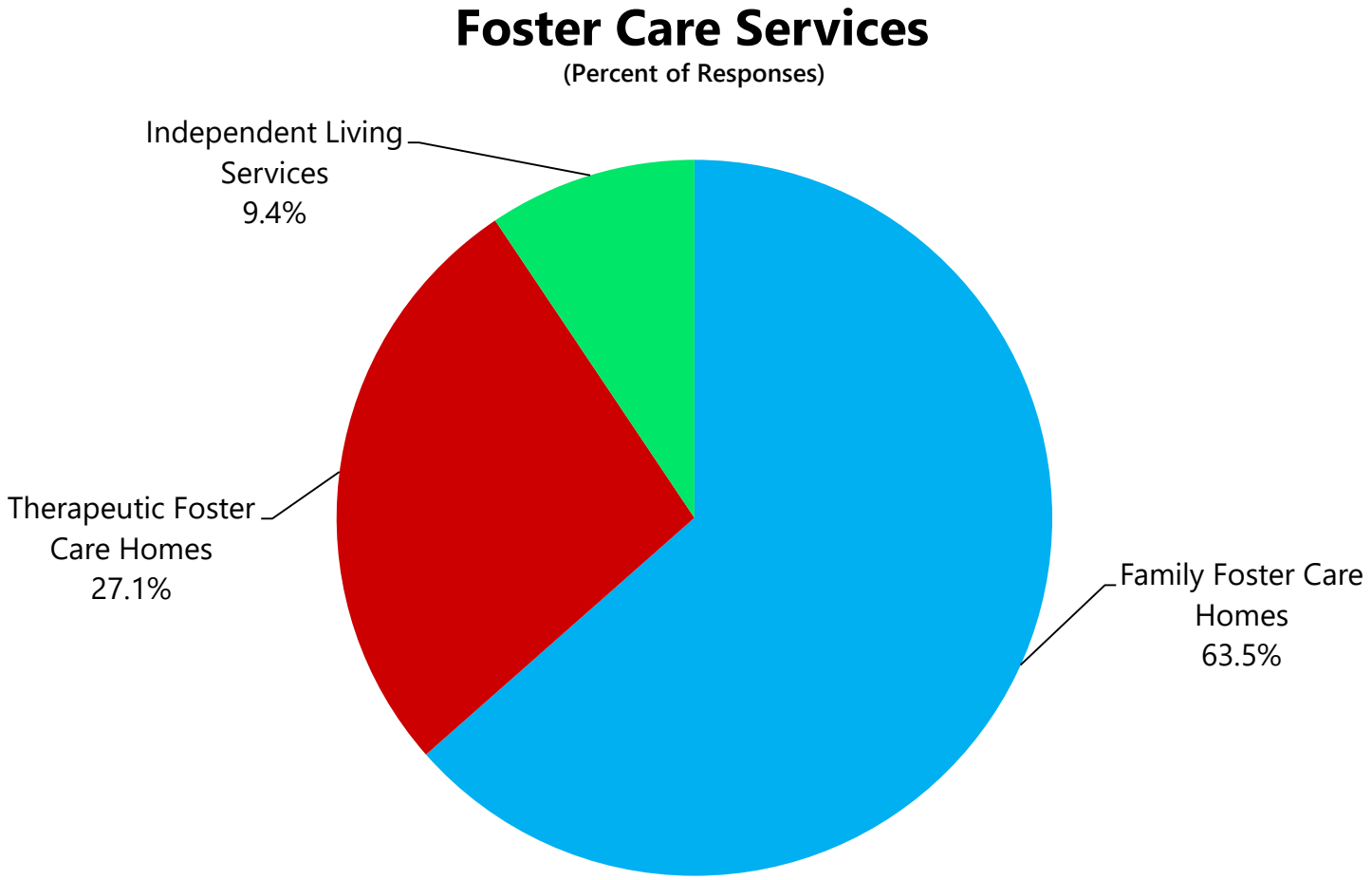


Populations and Age Groups with Gaps in Community-Based Behavioral Health Services: Statewide

Top Three Populations with Gaps	Number of Responses	Percent of Responses (n=295)
Autism	42	14.2%
Youth with Multiple Mental Health Diagnoses	42	14.2%
Sex Offending/Sexually Reactive Behaviors	32	10.9%

Top Three Age Groups with Gaps	Number of Responses	Percent of Responses (n=221)
Middle School Age (14-18)	45	20.4%
High School Age (11-13)	43	19.5%
Elementary School Age (6-10)	40	18.1%

Service Gaps: Statewide



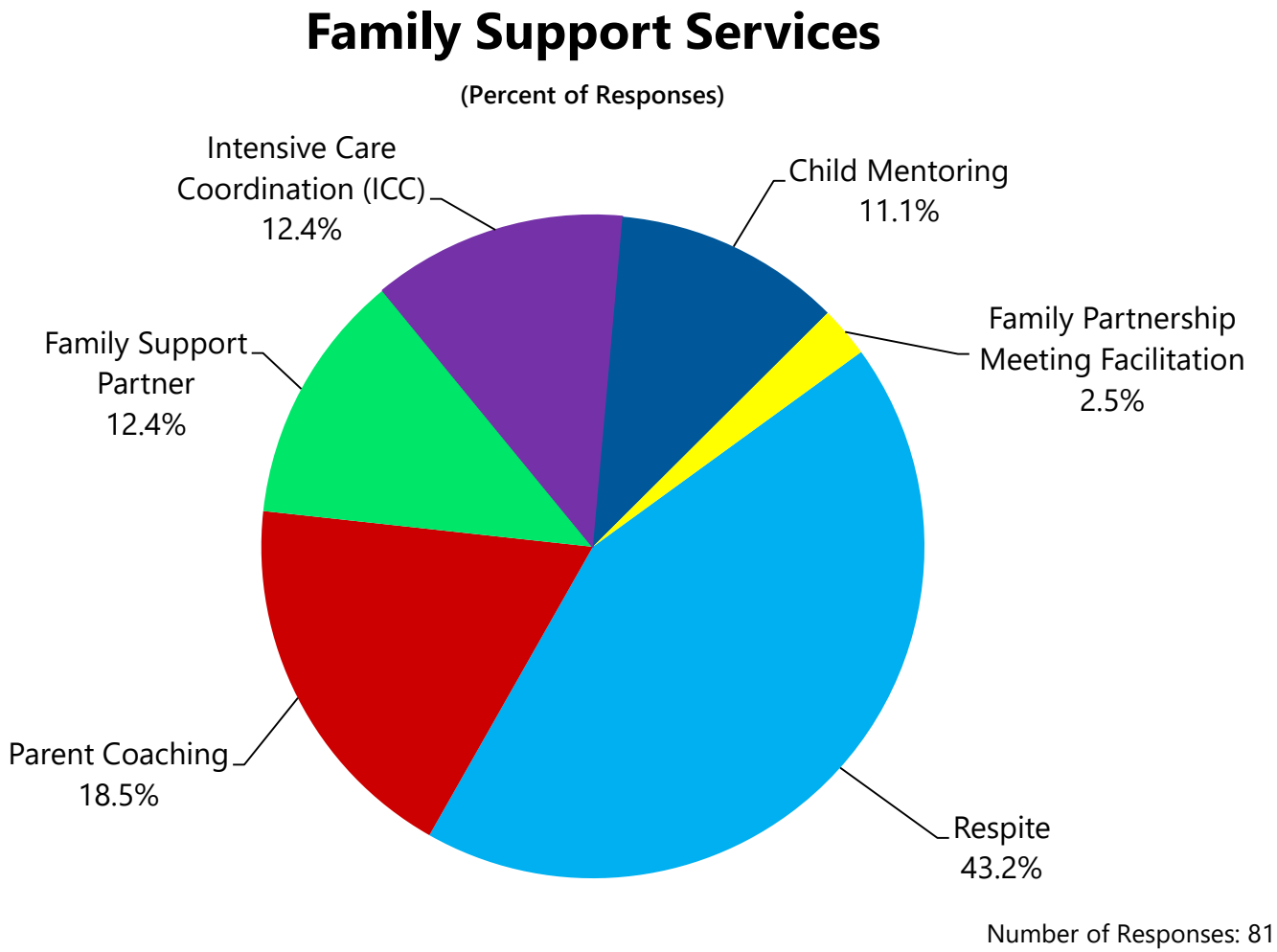
Number of Responses: 85

Populations and Age Groups with Gaps in Foster Care Services: Statewide

Top Three Populations with Gaps	Number of Responses	Percent of Responses (n=244)
Sex Offending/Sexually Reactive Behaviors	32	13.1%
Youth with Multiple Mental Health Diagnoses	32	13.1%
Potentially Disrupting or Disrupted Foster Care Placements	27	11.1%

Top Three Age Groups with Gaps	Number of Responses	Percent of Responses (n=171)
High School Age (14-18)	49	28.7%
Middle School Age (11-13)	39	22.8%
Elementary School Age (6-10)	24	14.0%

Service Gaps: Statewide

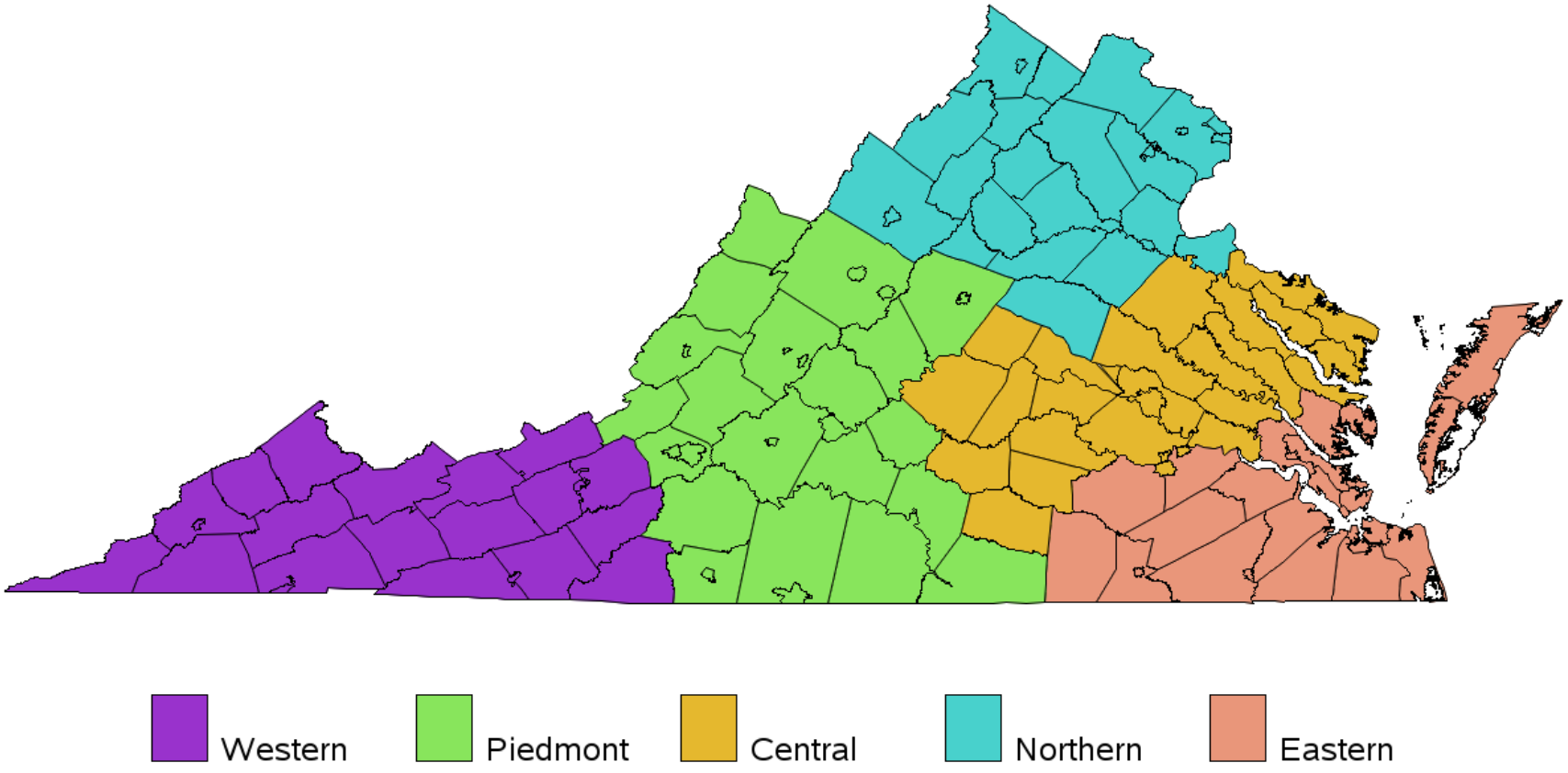


Populations and Age Groups with Gaps in Family Support Services: Statewide

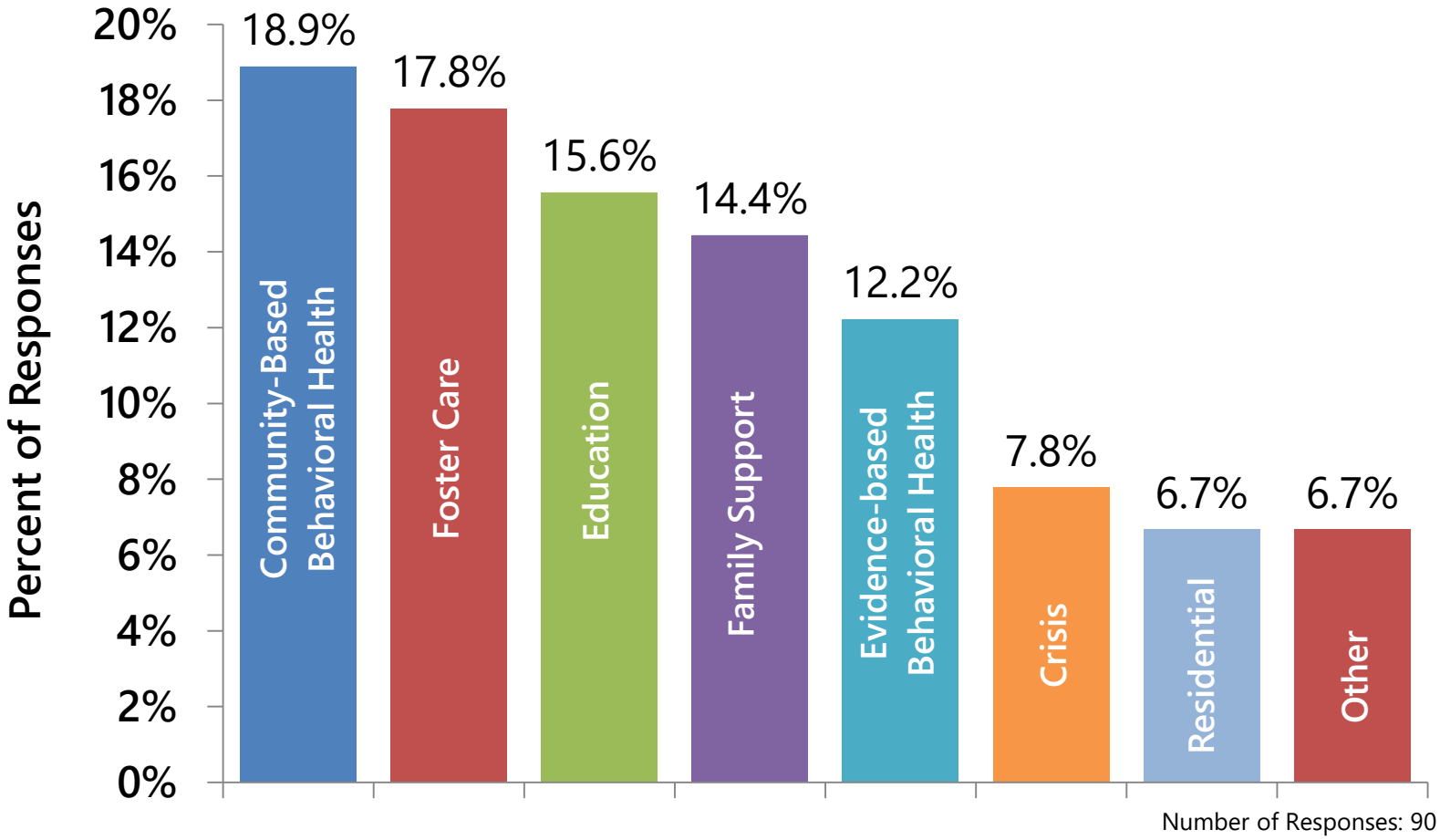
Top Three Populations with Gaps	Number of Responses	Percent of Responses (n=239)
Youth with Multiple Mental Health Diagnoses	33	13.8%
Autism	30	12.6%
intellectual Disability/Developmental Disability	29	12.1%

Top Three Age Groups with Gaps	Number of Responses	Percent of Responses (n=174)
High School Age (14-18)	39	22.4%
Middle School Age (11-13)	36	20.7%
Elementary School Age (6-10)	34	19.5%

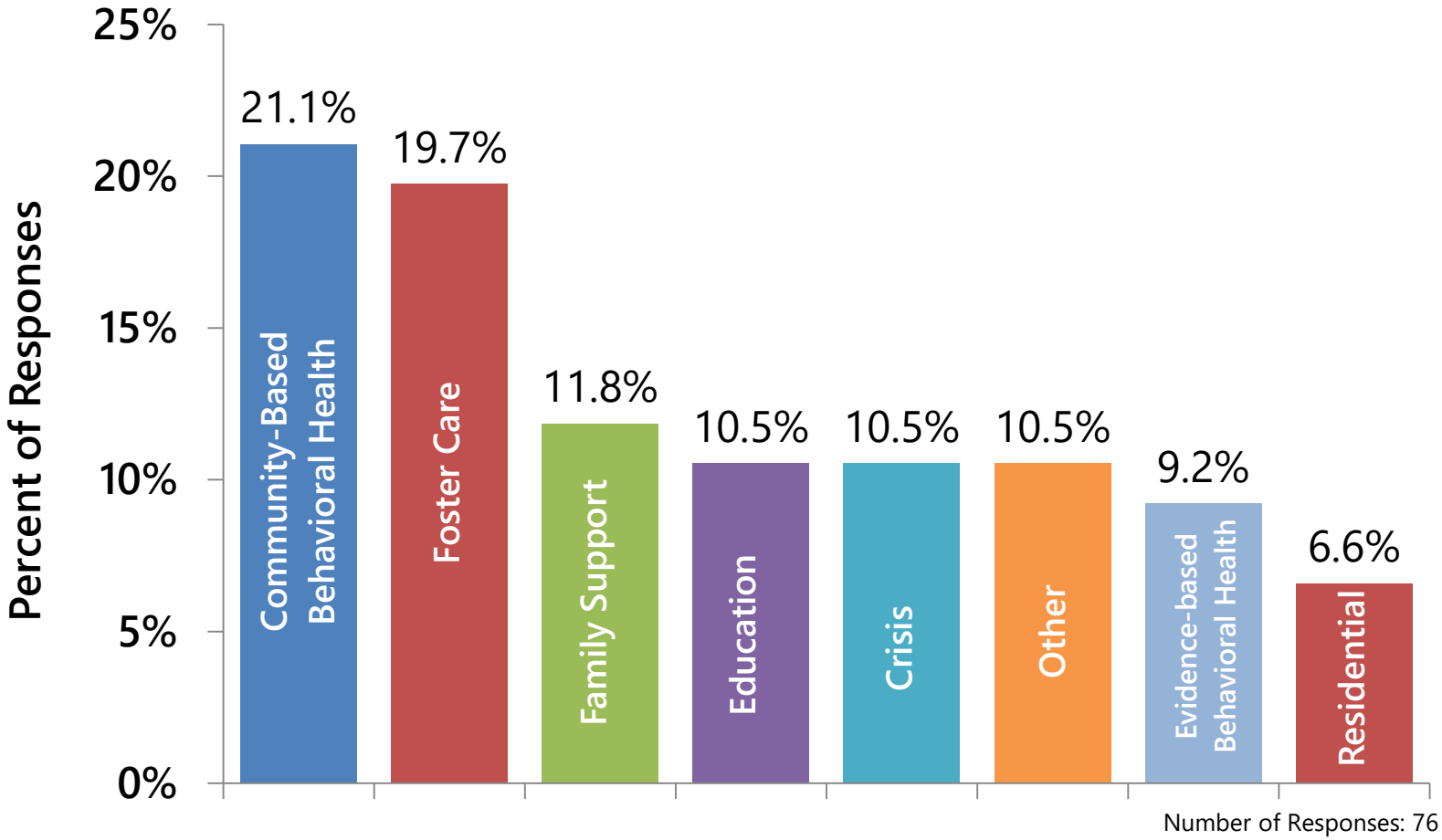
Regional Boundaries



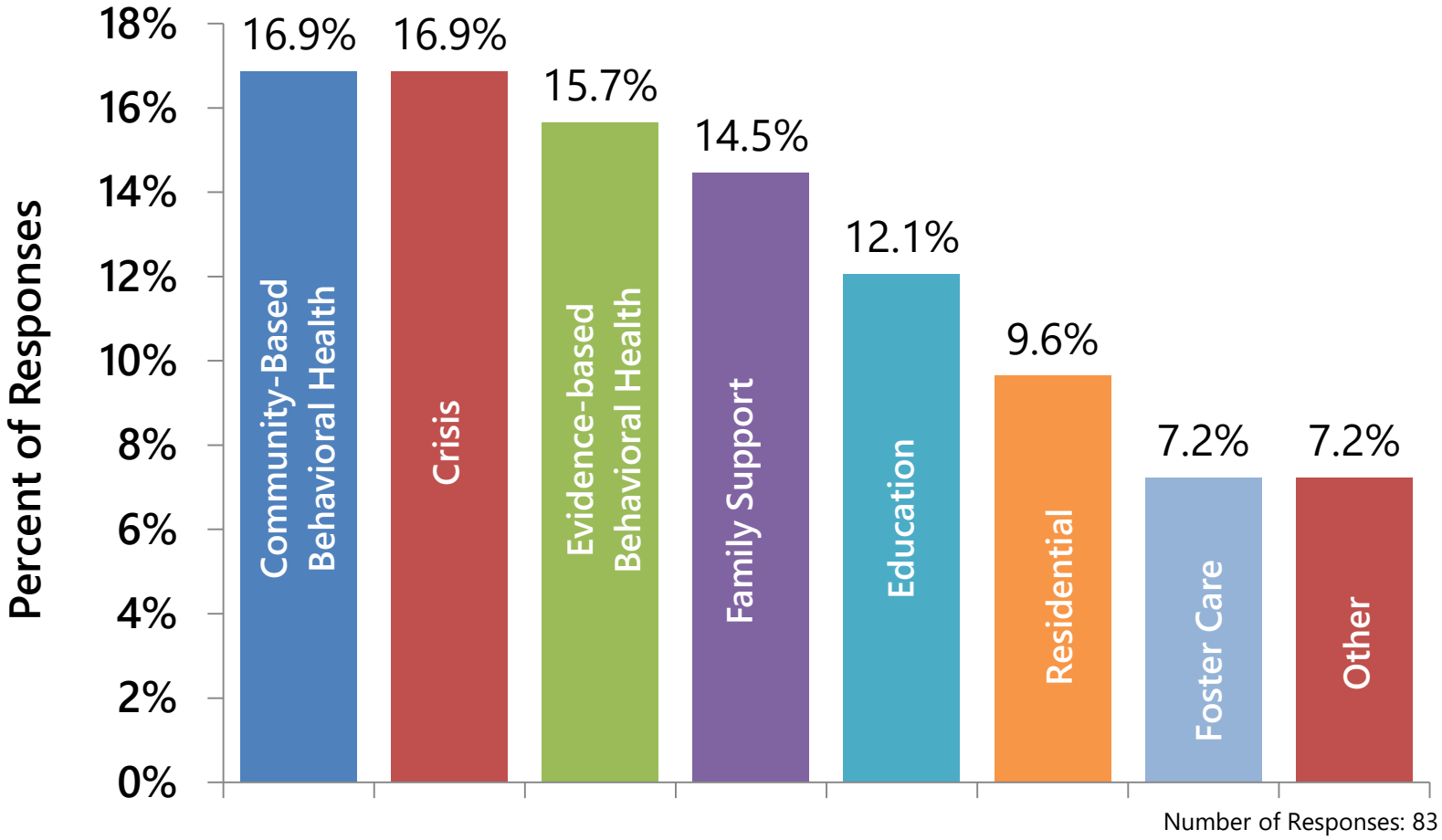
Gaps Grouped by Type of Service: Central Region



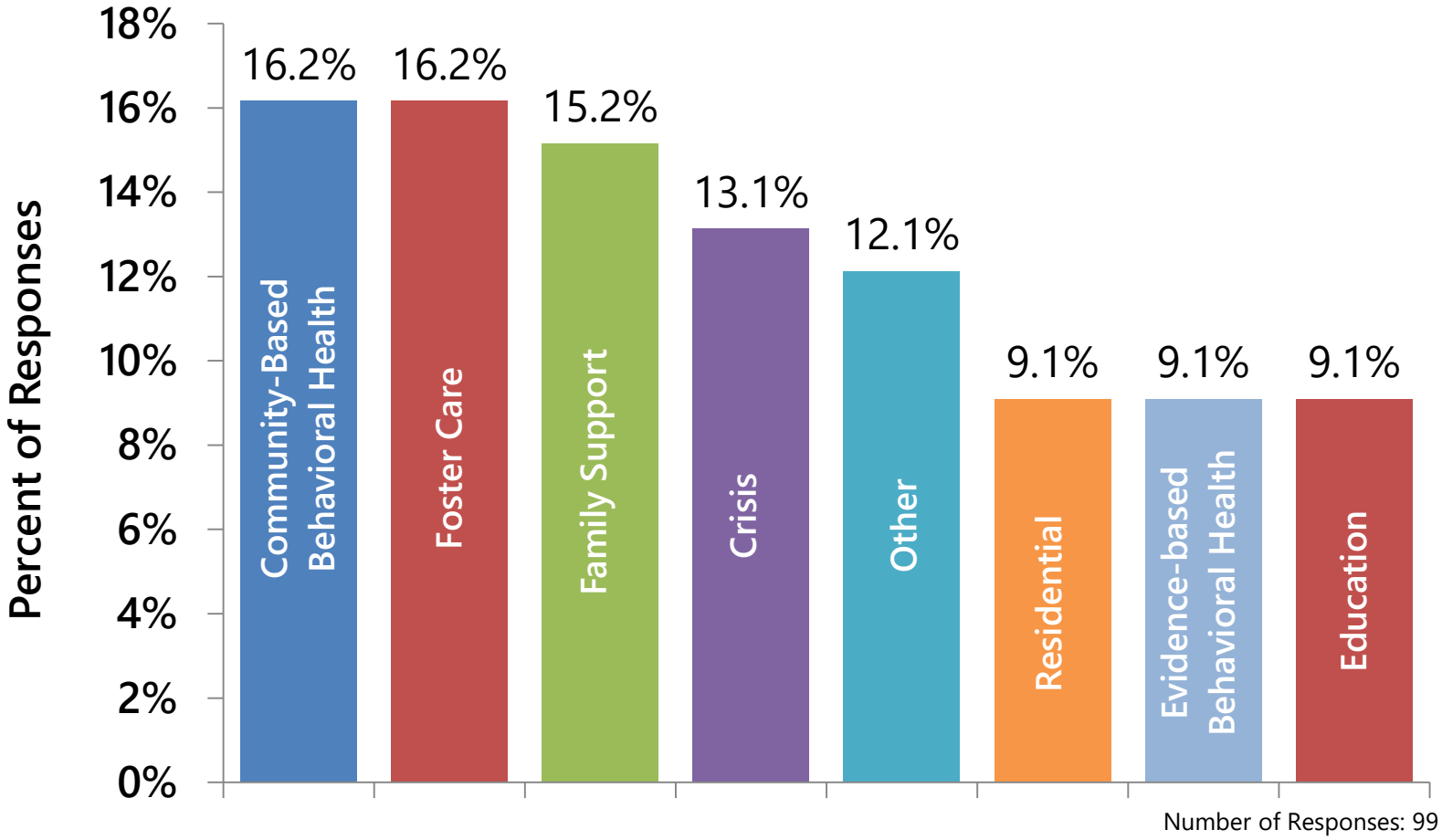
Gaps Grouped by Type of Service: Eastern Region



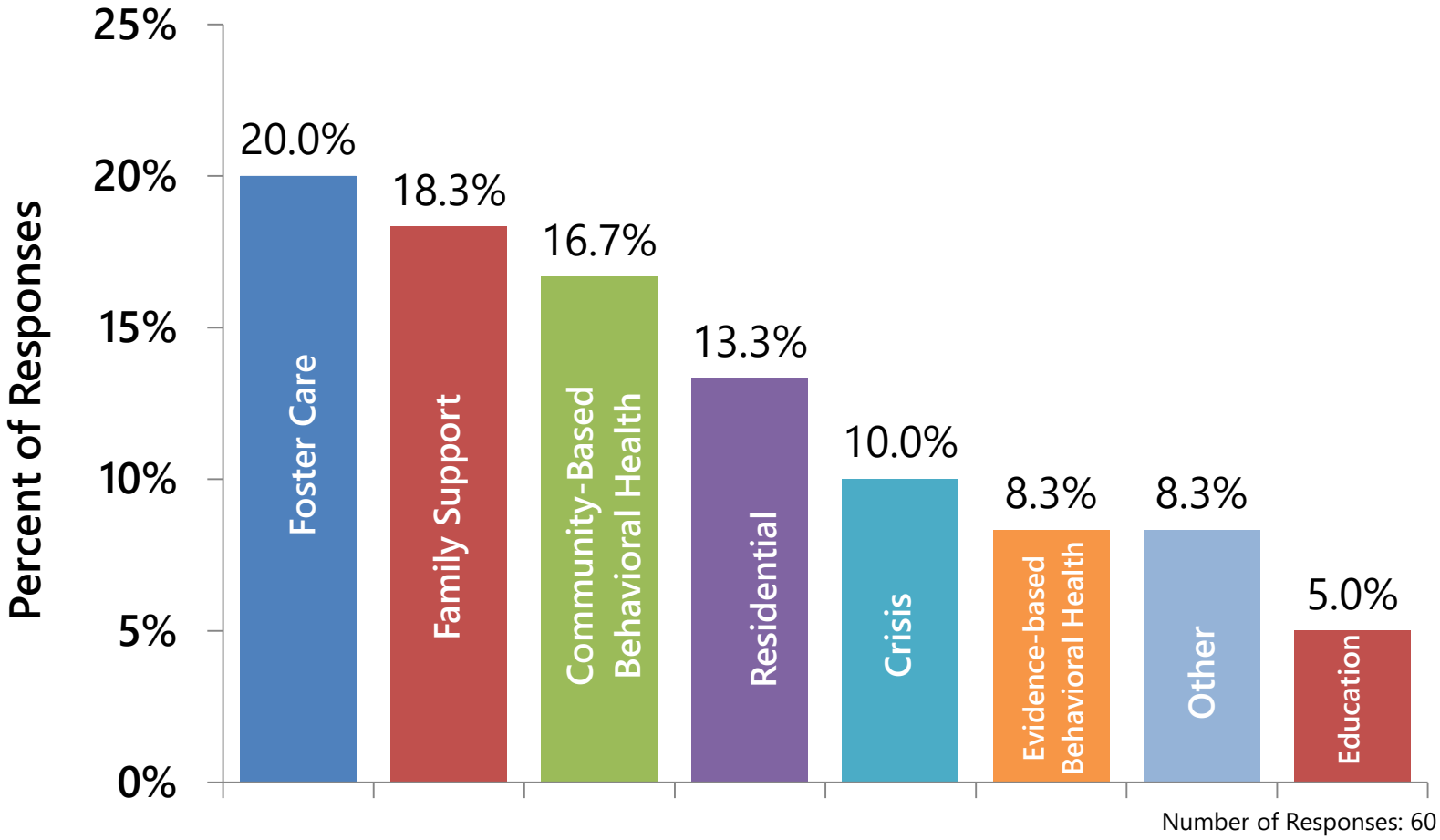
Gaps Grouped by Type of Service: Northern Region



Gaps Grouped by Type of Service: Piedmont Region



Gaps Grouped by Type of Service: Western Region



Level of Impact Barrier has had on the Ability to Develop Services

"Need For Collaboration and Consensus"

Rating	Cases	Percent
1	26	25.0%
2	31	29.8%
3	31	29.8%
4	12	11.5%
5	4	3.9%
Total	104	100.0%
Average: 2.4		

1 = "Not At All"
5 = "A Great Deal"

Level of Impact Barrier has had on the Ability to Develop Services

"Lack Of Funding"

Rating	Cases	Percent
1	15	14.4%
2	14	13.5%
3	21	20.2%
4	21	20.2%
5	33	31.7%
Total	104	100.0%
Average: 3.4		

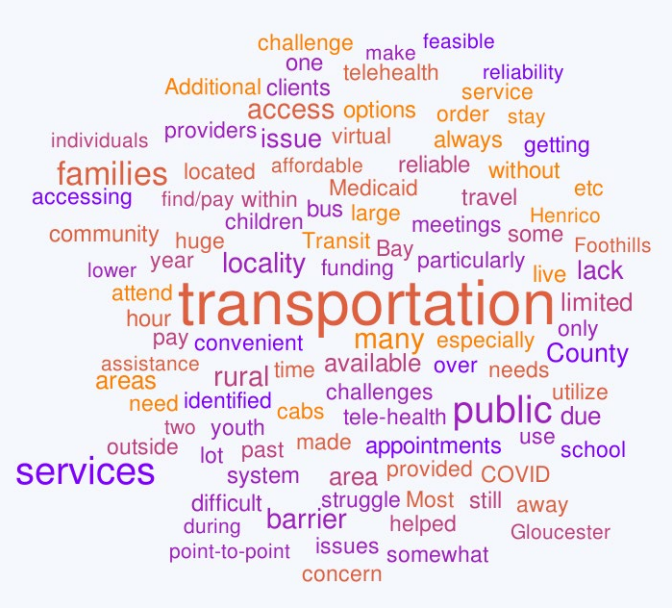
1 = "Not At All"
5 = "A Great Deal"

Level of Impact Barrier has had on the Ability to Develop Services

"Lack Of Transportation"

Rating	Cases	Percent
1	10	9.6%
2	6	5.8%
3	17	16.4%
4	30	28.9%
5	41	39.4%
Total	104	100.0%
Average: 3.8		

1 = "Not At All"
5 = "A Great Deal"



Level of Impact Barrier has had on the Ability to Develop Services

"Provider Availability"

Rating	Cases	Percent
1	3	2.9%
2	8	7.7%
3	28	17.3%
4	23	22.1%
5	52	50.0%
Total	104	100.0%
Average: 4.1		

1 = "Not At All"
5 = "A Great Deal"

Level of Impact Barrier has had on the Ability to Develop Services

"Need More information and Data"

Rating	Cases	Percent
1	33	31.7%
2	27	26.0%
3	32	30.8%
4	9	8.7%
5	3	2.9%
Total	104	100.0%
Average: 2.3		

1 = "Not At All"
5 = "A Great Deal"

Level of Impact Barrier has had on the Ability to Develop Services

"Other Barriers"

Rating	Cases	Percent
1	8	10.5%
2	1	1.3%
3	12	15.8%
4	18	23.7%
5	37	48.7%
Total	76	100.0%
Average: 4.0		

1 = "Not At All"
5 = "A Great Deal"

Has your locality initiated actions over the past year to address the perceived services barriers?

Answer	Cases	Percent
Yes	84	80.8%
No	20	19.2%
Total	104	100.0%

Conclusions

- As a group, gaps in Community-based Behavioral Services were identified most often statewide and in 4 out of 5 regions
- However, Family Foster Care Homes were selected as the top individual service gap in the Commonwealth and in every region except the Northern region
- Youth with Multiple Mental Health Diagnoses were identified as the population with gaps most frequently statewide and either 1st or 2nd in each region
- High School Age children (14 – 18) were the age group selected most often statewide and in every region

COMMONWEALTH of VIRGINIA

OFFICE OF CHILDREN'S SERVICES
Administering the Children's Services Act

Scott Reiner, M.S.
Executive Director

ADMINISTRATIVE MEMORANDUM #21-13

To: CPMT Chairs
CSA Coordinators
CSA Fiscal Agents

From: Kristy Wharton, Finance and Business Operation Manager

Date: June 4, 2021

Subject: FY2021 Administrative Budget Plan
FY2022 Administrative Budget Plan Funding
New Transaction History Report Showing Administrative History Information

FY2021 Administrative Budget Plan:

Please review your Transaction History Report to confirm your locality has requested their funds. FY2021 Administrative Budget Plan funds request must be approved by the Locality Fiscal Agent by June 15, 2021. The system will close on mid-night June 15, 2021. After this date, requests for FY2021 Administrative Funds will not be accepted.

FY2022 Administrative Budget Plan Funding:

The process for localities to request their Local CSA Administrative funds in FY2022 will stay the same. The current process no longer requires a paper submission, physical signatures, or the mailing of the request to the Department of Education.

The procedure is electronic, done through the CSA Local Government Reporting System. The CSA Coordinator originates the process; the CPMT Chair and the Fiscal Agent then sequentially approve it. Once initiated, an e-mail notification will occur at each stage alerting the appropriate individual of the need to take action, the individual needs to login to CSA Local Government Reporting System to approve the request. After the local Fiscal Agent has approved and submitted the Administrative Budget Plan, OCS recommends that the locality print and retain a copy.

FY2022 Administrative Budget Plan funds request must be processed between July 8, 2021 and June 15, 2022. The system will close at mid-night June 15, 2022. After this date, requests for the FY2022 Administrative Funds will not be accepted.

Attached to this memorandum is a table showing each locality's FY2022 CSA Administrative Budget Plan Allocation.

New Transaction History Report Showing Administrative History Information:

This report has been modified to display the Administrative Allocation Section. If there is a message stating that the "Locality has NOT filed the Administrative Plan for current Fiscal Year", the CSA Coordinator needs to submit the Administrative Plan in the LEDRS system. The Administrative Plan needs to be filed and approved fully by the Locality by June 15, 2022. The first column indicates the current status of the Administrative fund request. There will be a row visible if Administrative funds have been requested. The Administrative fund request has various approval stages, if the status is;

0 the CSA Coordinator has pended the Admin Plan Request;
1 the CSA Coordinator has submitted the Admin Plan Request;
3 the Locality CPMT Chair has approved the Admin Plan and
5 the Locality Fiscal Agent has approved it.

If the status is a 0, 1 or 3, then the Locality needs to take action. If it is in status 5 everything at the local level has been completed waiting for DOE payment, at which time it will become a status 9.

Questions about the Administrative Budget Plan process may be directed to the OCS Finance and Business Operation Manager, Kristy Wharton at kristy.wharton@csa.virginia.gov or OCS IT Director Preetha Agrawal at preetha.agrawal@csa.virginia.gov

Thank you for your cooperation.

FY2022 Children's Services Act
Administrative Budget Plan Allocation

FY22 CSA Administrative Allocations Locality	Local Match Rate	Total State Share	Total Local Share	Total Allocation
ACCOMACK	23.32%	10,787	3,281	14,068
ALBEMARLE	44.74%	21,785	17,637	39,422
ALLEGHANY	19.24%	21,909	5,220	27,129
AMELIA	32.68%	10,787	5,237	16,024
AMHERST	27.22%	10,787	4,034	14,821
APPOMATTOX	26.39%	10,787	3,867	14,654
ARLINGTON	46.02%	43,149	36,779	79,928
AUGUSTA	33.02%	10,787	5,318	16,105
BATH	42.78%	10,787	8,064	18,851
BEDFORD COUNTY**	33.60%	31,606	15,993	47,599
BLAND	21.09%	10,787	2,883	13,670
BOTETOURT	36.02%	10,787	6,074	16,861
BRUNSWICK	24.39%	10,787	3,480	14,267
BUCHANAN	31.56%	10,787	4,974	15,761
BUCKINGHAM	20.23%	10,787	2,736	13,523
CAMPBELL	31.07%	10,787	4,863	15,650
CAROLINE	33.08%	10,787	5,332	16,119
CARROLL	29.10%	10,787	4,427	15,214
CHARLES CITY	31.31%	10,787	4,916	15,703
CHARLOTTE	22.04%	10,787	3,050	13,837
CHESTERFIELD	38.53%	43,149	27,048	70,197
CLARKE	47.97%	10,787	9,946	20,733
CRAIG	29.01%	10,787	4,409	15,196
CULPEPER	37.67%	10,787	6,519	17,306
CUMBERLAND	30.40%	10,787	4,712	15,499
DICKENSON	30.42%	10,787	4,715	15,502
DINWIDDIE	33.58%	10,787	5,453	16,240
ESSEX	38.53%	10,787	6,762	17,549
FAIRFAX CITY/CNTY/FALLS CH	46.11%	43,149	36,926	80,075
FAUQUIER	45.84%	14,419	12,202	26,621
FLOYD	23.24%	10,787	3,266	14,053
FLUVANNA	38.11%	10,787	6,643	17,430
FRANKLIN CO	28.30%	10,787	4,257	15,044
FREDERICK	43.48%	16,130	12,411	28,541
GILES	28.98%	10,787	4,401	15,188
GLOUCESTER	36.87%	10,787	6,300	17,087
GOOCHLAND	48.71%	10,787	10,243	21,030
GRAYSON	21.09%	10,787	2,882	13,669
GREENE	34.71%	10,787	5,735	16,522
GREENSVILLE/EMPORIA	22.66%	10,787	3,160	13,947

FY2022 Children's Services Act
Administrative Budget Plan Allocation

FY22 CSA Administrative Allocations Locality	Local Match Rate	Total State Share	Total Local Share	Total Allocation
HALIFAX/SOUTH BOSTON	23.35%	10,787	3,287	14,074
HANOVER	44.44%	19,931	15,941	35,872
HENRICO	37.55%	43,149	25,944	69,093
HENRY	27.86%	10,787	4,165	14,952
HIGHLAND	38.22%	10,787	6,672	17,459
ISLE OF WIGHT	36.13%	10,787	6,103	16,890
JAMES CITY COUNTY	44.83%	10,787	8,767	19,554
KING AND QUEEN	31.44%	10,787	4,947	15,734
KING GEORGE	36.27%	10,787	6,139	16,926
KING WILLIAM	38.53%	10,787	6,761	17,548
LANCASTER	43.91%	10,787	8,444	19,231
LEE	22.45%	10,787	3,122	13,909
LOUDOUN	47.64%	42,695	38,839	81,534
LOUISA	44.01%	10,787	8,480	19,267
LUNENBURG	16.98%	10,787	2,206	12,993
MADISON	33.55%	10,787	5,445	16,232
MATHEWS	42.71%	10,787	8,042	18,829
MECKLENBURG	22.86%	10,787	3,197	13,984
MIDDLESEX	43.33%	10,787	8,248	19,035
MONTGOMERY	28.34%	14,777	5,844	20,621
NELSON	31.32%	10,787	4,919	15,706
NEW KENT	43.29%	10,787	8,234	19,021
NORTHAMPTON	19.71%	10,787	2,649	13,436
NORTHUMBERLAND	33.04%	10,787	5,323	16,110
NOTTOWAY	26.86%	10,787	3,962	14,749
ORANGE	40.83%	10,787	7,445	18,232
PAGE	28.65%	11,191	4,495	15,686
PATRICK	25.39%	10,787	3,671	14,458
PITTSYLVANIA	23.55%	10,787	3,324	14,111
POWHATAN	43.42%	10,787	8,277	19,064
PRINCE EDWARD	22.32%	10,787	3,099	13,886
PRINCE GEORGE	37.16%	10,787	6,379	17,166
PRINCE WILLIAM	34.14%	43,149	22,366	65,515
PULASKI	29.23%	10,787	4,455	15,242
RAPPAHANNOCK	41.99%	10,787	7,808	18,595
RICHMOND CO	32.27%	10,787	5,140	15,927
ROANOKE COUNTY	43.97%	16,693	13,100	29,793
ROCKBRIDGE	23.36%	10,787	3,289	14,076
ROCKINGHAM	34.45%	16,690	8,773	25,463
RUSSELL	18.94%	10,787	2,520	13,307

FY2022 Children's Services Act
Administrative Budget Plan Allocation

FY22 CSA Administrative Allocations Locality	Local Match Rate	Total State Share	Total Local Share	Total Allocation
SCOTT	31.54%	10,787	4,970	15,757
SHENANDOAH	35.17%	12,634	6,853	19,487
SMYTH	23.37%	10,787	3,290	14,077
SOUTHAMPTON	32.30%	10,787	5,148	15,935
SPOTSYLVANIA	45.88%	15,983	13,547	29,530
STAFFORD	44.39%	14,550	11,616	26,166
SURRY	39.79%	10,787	7,129	17,916
SUSSEX	23.87%	10,787	3,383	14,170
TAZEWELL	24.55%	10,787	3,511	14,298
WARREN	38.53%	11,782	7,385	19,167
WASHINGTON	27.60%	10,787	4,112	14,899
WESTMORELAND	30.25%	10,787	4,679	15,466
WISE	27.55%	10,787	4,102	14,889
WYTHE	27.08%	10,787	4,006	14,793
YORK	38.88%	10,787	6,863	17,650
ALEXANDRIA	53.09%	43,149	48,835	91,984
BRISTOL	25.47%	10,787	3,686	14,473
BUENA VISTA	23.29%	10,787	3,275	14,062
CHARLOTTESVILLE	30.68%	20,631	9,132	29,763
CHESAPEAKE	37.15%	43,149	25,509	68,658
COLONIAL HTS.	40.27%	10,787	7,272	18,059
COVINGTON	24.96%	10,787	3,588	14,375
DANVILLE	22.23%	15,723	4,493	20,216
FRANKLIN CITY	37.10%	10,787	6,364	17,151
FREDERICKSBURG	34.41%	10,787	5,659	16,446
GALAX	31.46%	10,787	4,951	15,738
HAMPTON	32.23%	43,149	20,518	63,667
HARRISONBURG	38.08%	10,787	6,635	17,422
HOPEWELL	26.67%	10,787	3,924	14,711
LEXINGTON	33.02%	10,787	5,318	16,105
LYNCHBURG	27.36%	35,322	13,307	48,629
MANASSAS	41.68%	14,244	10,178	24,422
MANASSAS PARK	42.73%	10,787	8,050	18,837
MARTINSVILLE	33.21%	10,787	5,364	16,151
NEWPORT NEWS	27.73%	43,149	16,557	59,706
NORFOLK	24.55%	43,149	14,039	57,188
NORTON	32.54%	10,787	5,203	15,990
PETERSBURG	35.35%	43,149	23,593	66,742
POQUOSON	27.87%	10,787	4,168	14,955
PORTSMOUTH	26.05%	43,149	15,200	58,349

FY2022 Children's Services Act
Administrative Budget Plan Allocation

FY22 CSA Administrative Allocations Locality	Local Match Rate	Total State Share	Total Local Share	Total Allocation
RADFORD	20.35%	10,787	2,755	13,542
RICHMOND CITY	36.91%	43,149	25,241	68,390
ROANOKE CITY	30.72%	43,149	19,136	62,285
SALEM	35.13%	10,787	5,842	16,629
STAUNTON	26.99%	10,787	3,987	14,774
SUFFOLK	24.32%	13,457	4,325	17,782
VIRGINIA BEACH	35.69%	43,149	23,945	67,094
WAYNESBORO	38.43%	13,636	8,511	22,147
WILLIAMSBURG	45.53%	10,787	9,017	19,804
WINCHESTER	45.87%	13,786	11,684	25,470
Total		2,060,000	1,115,831	3,175,831

COMMONWEALTH of VIRGINIA

Scott Reiner, M.S.
Executive Director

OFFICE OF CHILDREN'S SERVICES

ADMINISTRATIVE MEMO #21-14

To: CPMT Chairs
CSA Report Preparers
CSA Coordinators
CSA Fiscal Agents

From: Kristy Wharton, Business and Finance Manager

Date: June 7, 2021

Subject: FY2021 CSA Program Expenditure Year End Instructions
FY2022 Base Pool and Protected (Non-Mandated) Funds Allocations
FY2022 WRAP-Around Services for Students with Disabilities Allocations
FY2022 Expenditure Reporting

FY2021 Year-End Reimbursement Processing:

During the months of July, August and September, LEDRS can accept expenditures incurred in multiple fiscal years. During the months of July and August, a locality can only submit one LEDRS file each month. In the month of September, a locality can submit up to three (3) LEDRS files.

The LEDRS file for the months of July, August, and September will contain expenditure reimbursement data from the locality for the previous fiscal year (FY2021) and current fiscal year (FY2022) in a single submission. The system separates the submitted data (into FY2021 and FY2022) based on the purchase order fiscal year. Therefore, a locality should review both FY2021 and FY2022 components of data reimbursement requests before the Fiscal Agent approves the July, August, and September LEDRS submissions.

All FY2021 reimbursement requests for CSA services incurred during July 1, 2020 through June 30, 2021, must be approved by the local CSA fiscal agent in LEDRS before midnight September 30, 2021. Late submissions will not be accepted for reimbursement. Please reference SEC Policy 4.5.2 for more detailed information.

Requests for waivers to the September 30 reporting requirement must be submitted in writing and will be considered only if a local government can demonstrate mitigating circumstances beyond their control.

FY2022 Base Pool and Protected (Non-Mandated) Funds Allocations:

Attached to this memorandum is a table, which shows the FY2022 Base Pool Allocation by locality. The amount shown in the table will be the locality's Base Pool Allocation which will be reflected in the CSA Transaction History Report. The table also reflects an estimated required local base match required to receive the state's allocation. Please carefully review the amount allocated to your locality.

The Protected (Non-Mandated) funds are a subset of the locality's Base Pool Allocation. The Protected funds are not additional funds. It is a portion of the Base Pool Allocation that your locality can use to provide services to the non-mandated population. Also, attached to this memo is a PDF file, which reflects the FY2022 Protected funds associated with a locality's Base Pool Allocation.

FY2022 Wraparound Services for Students with Disabilities Funds:

The FY2022 allocation for "Wraparound Services for Students with Disabilities" (SPEDWRAP funds) is $2,200,000. This specific appropriation represents a continuation of the CSA 'earmark" funding for this particular service category.

This limited appropriation has several restrictions on expenditures in this category. The state share of reimbursement for these expenditures may not exceed $2.2 million statewide, nor can the appropriation be used for other service categories. As with all state appropriations, any unexpended allocation cannot be carried forward from one fiscal year to the next. The Office of Children's Services (OCS) must allocate and manage these funds in such a manner as to ensure compliance with these restrictions.

The use of the funds for "Wraparound Services for Students with Disabilities" allows localities to provide services to youth when their identified educational disabilities affect adjustment outside the school environment. Such services may provide critical support for youth who face significant challenges in the home or community. Communities are encouraged to consider their local policies regarding the provision of SPED Wraparound services and to identify strategies to maximize the utilization of community-based supports for all youth.

The allocation and management of the funds are based on the following principles:
1. All localities should have an opportunity to utilize the funds;
2. All localities should have access to the funds; and
3. 100% of the earmarked funds will be available for allocation.

The process for allocation and management of the FY2022 SPED Wrap-Around funds will be the same as prior years.
1. The initial allocation to localities is based on the locality's average utilization of these funds over the prior three (3) years.
2. If a locality does not receive SPED Wraparound funds in the initial allocation (due to historical non-utilization) or if a locality needs additional SPED Wraparound funds above those initially allocation, the locality can request funds by completing the automated SPEDWRAP Request Form process described on the CSA website under Resources - > Forms. Submit the form as instructed for funding consideration.

3. In January 2023, any locality that has not posted SPED Wraparound expenditures to LEDRS, will risk having their allocation removed by OCS for reallocation to localities which are requesting SPED Wraparound funds

Requests for additional SPED Wraparound funds will be supported based on the availability of unallocated funds. The total state allocation cannot exceed $2,200,000.

FY2022 Expenditure Reporting:

The LEDRS System will open for FY2022 program service year reporting *(services provided from July 1, 2021 through June 30, 2022)* on August 1, 2021. The LEDRS will be the CSA expenditure system of record and shall be the source to report and calculate the state's share of CSA reimbursement to localities.

Beginning FY2022, the LEDRS file format has new elements and files submitted with FY2022 data should adhere to the new file format.

For additional information, please reference Administrative Memo #21-04 LEDRS File Layout Changes

Children's Services Act
FY2022 - Base Pool Allocation

FIPS ID	Locality Name	Local Pool Fund Match Rate	FY22 Total Base Allocation	FY22 State Base Allocation	FY22 Local Base Allocation
			-	-	-
1	Accomack	23.32%	639,861	490,616	149,245
3	Albemarle	44.74%	10,031,966	5,543,823	4,488,143
5	Alleghany/Clifton Forge	19.24%	1,425,868	1,151,512	274,356
7	Amelia	32.68%	625,395	421,014	204,381
9	Amherst	27.22%	1,783,522	1,298,113	485,409
11	Appomattox	26.39%	1,795,444	1,321,645	473,799
13	Arlington	46.02%	7,599,320	4,102,466	3,496,854
15	Augusta	33.02%	4,712,682	3,156,507	1,556,175
17	Bath	42.78%	107,375	61,442	45,933
19	Bedford County	31.11%	5,867,750	4,042,293	1,825,457
21	Bland	21.09%	292,282	230,638	61,644
23	Botetourt	36.02%	1,268,115	811,308	456,807
25	Brunswick	24.39%	805,571	609,091	196,480
27	Buchanan	31.56%	1,034,437	707,992	326,445
29	Buckingham	20.23%	1,346,264	1,073,913	272,351
31	Campbell	31.07%	3,847,074	2,651,713	1,195,361
33	Caroline	33.08%	1,565,246	1,047,462	517,784
35	Carroll	29.10%	3,390,518	2,403,960	986,558
36	Charles City	31.31%	463,558	318,436	145,122
37	Charlotte	22.04%	873,330	680,848	192,482
41	Chesterfield	38.53%	14,337,133	8,812,854	5,524,279
43	Clarke	47.97%	277,186	144,217	132,969
45	Craig	29.01%	511,470	363,076	148,394
47	Culpeper	37.67%	3,601,016	2,244,508	1,356,508
49	Cumberland	30.40%	992,291	690,602	301,689
51	Dickenson	30.42%	1,367,460	951,547	415,913
53	Dinwiddie	33.58%	2,195,424	1,458,233	737,191
57	Essex	38.53%	1,149,466	706,569	442,897
61	Fauquier	45.84%	5,029,828	2,724,343	2,305,485
63	Floyd	23.24%	925,465	710,379	215,086
65	Fluvanna	38.11%	2,597,587	1,607,616	989,971
67	Franklin County	28.30%	6,366,438	4,564,831	1,801,607
69	Frederick	43.48%	4,014,905	2,269,048	1,745,857
71	Giles	28.98%	1,931,864	1,372,030	559,834
73	Gloucester	36.87%	967,152	610,564	356,588
75	Goochland	48.71%	1,266,155	649,458	616,697
77	Grayson	21.09%	873,919	689,636	184,283
79	Greene	34.71%	1,193,414	779,186	414,228
83	Halifax	23.35%	3,292,656	2,523,716	768,940
85	Hanover	44.44%	6,601,728	3,667,966	2,933,762

Children's Services Act
FY2022 - Base Pool Allocation

FIPS ID	Locality Name	Local Pool Fund Match Rate	FY22 Total Base Allocation	FY22 State Base Allocation	FY22 Local Base Allocation
87	Henrico	37.55%	17,080,105	10,666,580	6,413,525
89	Henry	27.86%	1,497,837	1,080,606	417,231
91	Highland	38.22%	56,443	34,873	21,570
93	Isle of Wight	36.13%	279,590	178,567	101,023
95	James City	44.83%	1,825,638	1,007,125	818,513
97	King & Queen	31.44%	313,643	215,033	98,610
99	King George	36.27%	2,504,952	1,596,410	908,542
101	King William	38.53%	935,548	575,093	360,455
103	Lancaster	43.91%	908,691	509,692	398,999
105	Lee	22.45%	1,199,650	930,383	269,267
107	Loudoun	47.64%	8,442,239	4,420,726	4,021,513
109	Louisa	44.01%	3,712,506	2,078,565	1,633,941
111	Lunenburg	16.98%	971,966	806,956	165,010
113	Madison	33.55%	1,797,603	1,194,580	603,023
115	Mathews	42.71%	482,377	276,357	206,020
117	Mecklenburg	22.86%	2,121,988	1,636,813	485,175
119	Middlesex	43.33%	719,111	407,521	311,590
121	Montgomery	28.34%	1,007,675	722,100	285,575
125	Nelson	31.32%	1,379,451	947,395	432,056
127	New Kent	43.29%	692,281	392,592	299,689
131	Northampton	19.71%	465,363	373,625	91,738
133	Northumberland	33.04%	385,546	258,163	127,383
135	Nottoway	26.86%	1,140,713	834,305	306,408
137	Orange	40.83%	3,331,228	1,970,927	1,360,301
139	Page	28.65%	1,245,892	888,888	357,004
141	Patrick	25.39%	563,271	420,239	143,032
143	Pittsylvania	23.55%	5,003,025	3,824,608	1,178,417
145	Powhatan	43.42%	1,982,169	1,121,567	860,602
147	Prince Edward	22.32%	566,041	439,720	126,321
149	Prince George	37.16%	1,935,383	1,216,196	719,187
153	Prince William	34.14%	16,727,354	11,016,878	5,710,476
155	Pulaski	29.23%	2,794,679	1,977,902	816,777
157	Rappahannock	41.99%	1,776,436	1,030,515	745,921
159	Richmond County	32.27%	394,862	267,429	127,433
161	Roanoke County	43.97%	7,983,630	4,473,238	3,510,392
163	Rockbridge	23.36%	3,184,098	2,440,185	743,913
165	Rockingham	34.45%	6,401,133	4,195,725	2,205,408
167	Russell	18.94%	1,220,649	989,472	231,177
169	Scott	31.54%	803,301	549,942	253,359
171	Shenandoah	35.17%	4,736,504	3,070,877	1,665,627
173	Smyth	23.37%	1,693,558	1,297,784	395,774

Children's Services Act
FY2022 - Base Pool Allocation

FIPS ID	Locality Name	Local Pool Fund Match Rate	FY22 Total Base Allocation	FY22 State Base Allocation	FY22 Local Base Allocation
175	Southampton	32.30%	580,415	392,913	187,502
177	Spotsylvania	45.88%	12,673,600	6,859,485	5,814,115
179	Stafford	44.39%	6,753,383	3,755,260	2,998,123
181	Surry	39.79%	266,452	160,429	106,023
183	Sussex	23.87%	398,449	303,323	95,126
185	Tazewell	24.55%	1,774,439	1,338,728	435,711
187	Warren	38.53%	1,669,236	1,026,078	643,158
191	Washington	27.60%	1,690,544	1,223,943	466,601
193	Westmoreland	30.25%	1,631,844	1,138,139	493,705
195	Wise	27.55%	1,415,338	1,025,430	389,908
197	Wythe	27.08%	1,950,701	1,422,451	528,250
199	York	38.88%	1,804,129	1,102,598	701,531
510	Alexandria	53.09%	9,747,532	4,572,500	5,175,032
520	Bristol	25.47%	1,859,587	1,385,993	473,594
530	Buena Vista	23.29%	2,011,343	1,542,913	468,430
540	Charlottesville	30.68%	7,429,159	5,149,708	2,279,451
550	Chesapeake	37.15%	5,018,464	3,153,928	1,864,536
570	Colonial Heights	40.27%	1,141,899	682,062	459,837
580	Covington	24.96%	1,310,690	983,534	327,156
590	Danville	22.23%	3,882,350	3,019,444	862,906
620	Franklin City	37.10%	158,643	99,779	58,864
630	Fredericksburg	34.41%	2,665,312	1,748,179	917,133
640	Galax	31.46%	1,110,814	761,351	349,463
650	Hampton	32.23%	5,302,996	3,593,992	1,709,004
660	Harrisonburg	38.08%	4,455,887	2,758,960	1,696,927
670	Hopewell	26.67%	2,486,014	1,822,917	663,097
678	Lexington	33.02%	417,115	279,374	137,741
680	Lynchburg	27.36%	6,160,069	4,474,391	1,685,678
683	Manassas City	41.68%	1,389,480	810,402	579,078
685	Manassas Park	42.73%	920,930	527,379	393,551
690	Martinsville	33.21%	671,606	448,555	223,051
700	Newport News	27.73%	8,421,179	6,085,960	2,335,219
710	Norfolk	24.55%	8,877,785	6,698,448	2,179,337
720	Norton	32.54%	103,221	69,634	33,587
730	Petersburg	35.35%	3,811,468	2,464,114	1,347,354
735	Poquoson	27.87%	306,232	220,887	85,345
740	Portsmouth	26.05%	1,793,732	1,326,465	467,267
750	Radford	20.35%	629,363	501,317	128,046
760	Richmond City	36.91%	16,432,650	10,367,794	6,064,856
770	Roanoke City	30.72%	10,939,729	7,578,730	3,360,999
775	Salem	35.13%	2,254,134	1,462,259	791,875

Children's Services Act
FY2022 - Base Pool Allocation

FIPS ID	Locality Name	Local Pool Fund Match Rate	FY22 Total Base Allocation	FY22 State Base Allocation	FY22 Local Base Allocation
790	Staunton	26.99%	2,619,437	1,912,574	706,863
800	Suffolk	24.32%	1,587,797	1,201,614	386,183
810	Virginia Beach	35.69%	13,192,784	8,484,496	4,708,288
820	Waynesboro	38.43%	3,500,905	2,155,507	1,345,398
830	Williamsburg	45.53%	349,833	190,551	159,282
840	Winchester	45.87%	3,977,636	2,152,968	1,824,668
1200	Greensville/Emporia	22.66%	907,795	702,113	205,682
1300	Fairfax/Falls Church	46.11%	41,493,363	22,359,009	19,134,354
	Total		**433,179,727**	**275,499,901**	**157,679,826**

Children's Services Act

Allocation for WRAP FY2022

FY2022

FIPS	Locality	Local Match	FY	State and Local Share	State Share	Local Share
1	Accomack	23.32%	22	-	-	-
3	Albemarle	44.74%	22	81,017.00	44,770.00	36,247.00
5	Alleghany/Clifton Forge	19.24%	22	7,417.00	5,990.00	1,427.00
7	Amelia	32.68%	22	7,512.00	5,057.00	2,455.00
9	Amherst	27.22%	22	25,456.00	18,527.00	6,929.00
11	Appomattox	26.39%	22	6,870.00	5,057.00	1,813.00
13	Arlington	46.02%	22	61,812.00	33,366.00	28,446.00
15	Augusta	33.02%	22	7,550.00	5,057.00	2,493.00
17	Bath	42.78%	22	-	-	-
19	Bedford County	31.11%	22	-	-	-
21	Bland	21.09%	22	-	-	-
23	Botetourt	36.02%	22	10,069.00	6,442.00	3,627.00
25	Brunswick	24.39%	22	6,688.00	5,057.00	1,631.00
27	Buchanan	31.56%	22	-	-	-
29	Buckingham	20.23%	22	62,071.00	49,514.00	12,557.00
31	Campbell	31.07%	22	24,407.00	16,824.00	7,583.00
33	Caroline	33.08%	22	7,557.00	5,057.00	2,500.00
35	Carroll	29.09%	22	7,132.00	5,057.00	2,075.00
36	Charles City	31.31%	22	-	-	-
37	Charlotte	22.04%	22	12,219.00	9,526.00	2,693.00
41	Chesterfield	38.53%	22	25,313.00	15,560.00	9,753.00
43	Clarke	47.97%	22	9,719.00	5,057.00	4,662.00
45	Craig	29.01%	22	-	-	-
47	Culpeper	37.67%	22	91,728.00	57,174.00	34,554.00
49	Cumberland	30.40%	22	7,266.00	5,057.00	2,209.00
51	Dickenson	30.42%	22	19,805.00	13,780.00	6,025.00
53	Dinwiddie	33.58%	22	49,393.00	32,807.00	16,586.00
57	Essex	38.53%	22	-	-	-
61	Fauquier	45.84%	22	102,456.00	55,490.00	46,966.00
63	Floyd	23.24%	22	-	-	-
65	Fluvanna	38.11%	22	75,429.00	46,683.00	28,746.00
67	Franklin County	28.30%	22	119,709.00	85,831.00	33,878.00
69	Frederick	43.48%	22	20,518.00	11,597.00	8,921.00
71	Giles	28.98%	22	-	-	-
73	Gloucester	36.87%	22	9,899.00	6,249.00	3,650.00
75	Goochland	48.71%	22	-	-	-
77	Grayson	21.09%	22	-	-	-
79	Greene	34.71%	22	19,651.00	12,830.00	6,821.00
83	Halifax	23.35%	22	6,598.00	5,057.00	1,541.00
85	Hanover	44.44%	22	27,131.00	15,074.00	12,057.00
87	Henrico	37.55%	22	43,907.00	27,420.00	16,487.00
89	Henry	27.86%	22	-	-	-
91	Highland	38.22%	22	-	-	-

Children's Services Act
Allocation for WRAP FY2022

FY2022

FIPS	Locality	Local Match	FY	State and Local Share	State Share	Local Share
93	Isle of Wight	36.13%	22	-	-	-
95	James City	44.83%	22	-	-	-
97	King & Queen	31.44%	22	-	-	-
99	King George	36.27%	22	-	-	-
101	King William	38.53%	22	14,989.00	9,214.00	5,775.00
103	Lancaster	43.91%	22	9,016.00	5,057.00	3,959.00
105	Lee	22.45%	22	20,529.00	15,920.00	4,609.00
107	Loudoun	47.64%	22	36,381.00	19,049.00	17,332.00
109	Louisa	44.01%	22	9,032.00	5,057.00	3,975.00
111	Lunenburg	16.98%	22	11,350.00	9,423.00	1,927.00
113	Madison	33.55%	22	7,610.00	5,057.00	2,553.00
115	Mathews	42.71%	22	-	-	-
117	Mecklenburg	22.86%	22	62,470.00	48,189.00	14,281.00
119	Middlesex	43.33%	22	-	-	-
121	Montgomery	28.34%	22	-	-	-
125	Nelson	31.32%	22	7,363.00	5,057.00	2,306.00
127	New Kent	43.29%	22	-	-	-
131	Northampton	19.71%	22	-	-	-
133	Northumberland	33.04%	22	7,552.00	5,057.00	2,495.00
135	Nottoway	26.86%	22	-	-	-
137	Orange	40.83%	22	18,712.00	11,072.00	7,640.00
139	Page	28.65%	22	9,941.00	7,093.00	2,848.00
141	Patrick	25.39%	22	-	-	-
143	Pittsylvania	23.55%	22	14,120.00	10,795.00	3,325.00
145	Powhatan	43.42%	22	21,373.00	12,093.00	9,280.00
147	Prince Edward	22.32%	22	6,510.00	5,057.00	1,453.00
149	Prince George	37.16%	22	-	-	-
153	Prince William	34.14%	22	-	-	-
155	Pulaski	29.23%	22	48,494.00	34,319.00	14,175.00
157	Rappahannock	41.99%	22	15,527.00	9,007.00	6,520.00
159	Richmond County	32.27%	22	-	-	-
161	Roanoke County	43.97%	22	28,378.00	15,900.00	12,478.00
163	Rockbridge	23.36%	22	17,979.00	13,779.00	4,200.00
165	Rockingham	34.45%	22	7,715.00	5,057.00	2,658.00
167	Russell	18.94%	22	15,042.00	12,193.00	2,849.00
169	Scott	31.54%	22	-	-	-
171	Shenandoah	35.17%	22	32,493.00	21,065.00	11,428.00
173	Smyth	23.37%	22	-	-	-
175	Southampton	32.30%	22	-	-	-
177	Spotsylvania	45.88%	22	44,577.00	24,125.00	20,452.00
179	Stafford	44.39%	22	45,699.00	25,413.00	20,286.00
181	Surry	39.79%	22	-	-	-
183	Sussex	23.87%	22	6,643.00	5,057.00	1,586.00

Children's Services Act

Allocation for WRAP FY2022

FY2022

FIPS	Locality	Local Match	FY	State and Local Share	State Share	Local Share
185	Tazewell	24.55%	22	20,765.00	15,667.00	5,098.00
187	Warren	38.53%	22	8,227.00	5,057.00	3,170.00
191	Washington	27.60%	22	-	-	-
193	Westmoreland	30.25%	22	-	-	-
195	Wise	27.55%	22	109,104.00	79,046.00	30,058.00
197	Wythe	27.08%	22	-	-	-
199	York	38.88%	22	8,274.00	5,057.00	3,217.00
510	Alexandria	53.09%	22	78,838.00	36,983.00	41,855.00
520	Bristol	25.47%	22	-	-	-
530	Buena Vista	23.29%	22	6,592.00	5,057.00	1,535.00
540	Charlottesville	30.68%	22	43,790.00	30,355.00	13,435.00
550	Chesapeake	37.15%	22	100,560.00	63,202.00	37,358.00
570	Colonial Heights	40.27%	22	-	-	-
580	Covington	24.96%	22	-	-	-
590	Danville	22.23%	22	29,546.00	22,978.00	6,568.00
620	Franklin City	37.10%	22	-	-	-
630	Fredericksburg	34.41%	22	24,987.00	16,389.00	8,598.00
640	Galax	31.46%	22	-	-	-
650	Hampton	32.23%	22	70,772.00	47,962.00	22,810.00
660	Harrisonburg	38.08%	22	8,167.00	5,057.00	3,110.00
670	Hopewell	26.67%	22	65,991.00	48,391.00	17,600.00
678	Lexington	33.02%	22	-	-	-
680	Lynchburg	27.36%	22	48,637.00	35,330.00	13,307.00
683	Manassas City	41.68%	22	-	-	-
685	Manassas Park	42.73%	22	-	-	-
690	Martinsville	33.21%	22	-	-	-
700	Newport News	27.73%	22	-	-	-
710	Norfolk	24.55%	22	112,912.00	85,192.00	27,720.00
720	Norton	32.54%	22	7,496.00	5,057.00	2,439.00
730	Petersburg	35.35%	22	52,131.00	33,703.00	18,428.00
735	Poquoson	27.87%	22	-	-	-
740	Portsmouth	26.05%	22	-	-	-
750	Radford	20.35%	22	-	-	-
760	Richmond City	36.91%	22	-	-	-
770	Roanoke City	30.72%	22	7,299.00	5,057.00	2,242.00
775	Salem	35.13%	22	7,796.00	5,057.00	2,739.00
790	Staunton	26.99%	22	6,926.00	5,057.00	1,869.00
800	Suffolk	24.32%	22	-	-	-
810	Virginia Beach	35.69%	22	-	-	-
820	Waynesboro	38.43%	22	9,907.00	6,100.00	3,807.00
830	Williamsburg	45.53%	22	-	-	-
840	Winchester	45.87%	22	16,662.00	9,019.00	7,643.00
1200	Greensville/Emporia	22.66%	22	6,539.00	5,057.00	1,482.00

Children's Services Act

Allocation for WRAP FY2022

FY2022

FIPS	Locality	Local Match	FY	State and Local Share	State Share	Local Share
1300	Fairfax/Falls Church	46.11%	22	694,188.00	374,098.00	320,090.00
				3,021,900.00	1,900,000.00	1,121,900.00

Children's Services Act / Office of Children's Services

FY2022 - Base Pool (Protected) Allocations

ID	Locality Name	Local Pool Fund Base Match Rate	FY2022 State Max Protected Funds	FY2022 Local Match	Total Protected Funds
1	Accomack	23.32%	$ 38,655	11,759	$ 50,414
3	Albemarle	44.74%	$ 121,311	98,210	$ 219,521
5	Alleghany/Clifton Forge	19.24%	$ 42,892	10,219	$ 53,111
7	Amelia	32.68%	$ 10,000	4,855	$ 14,855
9	Amherst	27.22%	$ 85,122	31,830	$ 116,952
11	Appomattox	26.39%	$ 10,902	3,908	$ 14,810
13	Arlington	46.02%	$ 137,387	117,106	$ 254,493
15	Augusta	33.02%	$ 39,871	19,657	$ 59,528
17	Bath	42.78%	$ 10,000	7,476	$ 17,476
19	Bedford County	31.11%	$ 47,313	21,366	$ 68,679
21	Bland	21.09%	$ 10,000	2,673	$ 12,673
23	Botetourt	36.02%	$ 17,263	9,720	$ 26,983
25	Brunswick	24.39%	$ 16,926	5,460	$ 22,386
27	Buchanan	31.56%	$ 34,381	15,853	$ 50,234
29	Buckingham	20.23%	$ 15,461	3,921	$ 19,382
31	Campbell	31.07%	$ 80,361	36,226	$ 116,587
33	Caroline	33.08%	$ 19,958	9,866	$ 29,824
35	Carroll	29.10%	$ 22,749	9,336	$ 32,085
36	Charles City	31.31%	$ 10,000	4,557	$ 14,557
37	Charlotte	22.04%	$ 33,202	9,387	$ 42,589
41	Chesterfield	38.53%	$ 476,901	298,942	$ 775,843
43	Clarke	47.97%	$ 10,000	9,220	$ 19,220
45	Craig	29.01%	$ 10,000	4,087	$ 14,087
47	Culpeper	37.67%	$ 40,025	24,190	$ 64,215
49	Cumberland	30.40%	$ 84,607	36,961	$ 121,568
51	Dickenson	30.42%	$ 23,751	10,381	$ 34,132
53	Dinwiddie	33.58%	$ 63,456	32,079	$ 95,535
57	Essex	38.53%	$ 10,000	6,268	$ 16,268
61	Fauquier	45.84%	$ 92,484	78,265	$ 170,749
63	Floyd	23.24%	$ 22,353	6,768	$ 29,121
65	Fluvanna	38.11%	$ 26,170	16,116	$ 42,286
67	Franklin County	28.30%	$ 140,887	55,604	$ 196,491
69	Frederick	43.48%	$ 34,011	26,169	$ 60,180
71	Giles	28.98%	$ 15,850	6,467	$ 22,317
73	Gloucester	36.87%	$ 35,580	20,780	$ 56,360
75	Goochland	48.71%	$ 10,000	9,496	$ 19,496
77	Grayson	21.09%	$ 13,863	3,704	$ 17,567
79	Greene	34.71%	$ 12,396	6,590	$ 18,986
83	Halifax	23.35%	$ 38,098	11,608	$ 49,706
85	Hanover	44.44%	$ 84,600	67,666	$ 152,266
87	Henrico	37.55%	$ 429,722	258,380	$ 688,102
89	Henry	27.86%	$ 50,707	19,578	$ 70,285
91	Highland	38.22%	$ 10,000	6,185	$ 16,185
93	Isle of Wight	36.13%	$ 103,708	58,672	$ 162,380

ID	Locality Name	Local Pool Fund Base Match Rate	FY2022 State Max Protected Funds	FY2022 Local Match	Total Protected Funds
95	James City	44.83%	$ 34,872	28,341	$ 63,213
97	King & Queen	31.44%	$ 23,021	10,557	$ 33,578
99	King George	36.27%	$ 14,422	8,208	$ 22,630
101	King William	38.53%	$ 24,574	15,402	$ 39,976
103	Lancaster	43.91%	$ 10,000	7,828	$ 17,828
105	Lee	22.45%	$ 44,098	12,763	$ 56,861
107	Loudoun	47.64%	$ 298,840	271,853	$ 570,693
109	Louisa	44.01%	$ 46,717	36,724	$ 83,441
111	Lunenburg	16.98%	$ 92,169	18,847	$ 111,016
113	Madison	33.55%	$ 17,437	8,802	$ 26,239
115	Mathews	42.71%	$ 10,000	7,455	$ 17,455
117	Mecklenburg	22.86%	$ 79,344	23,519	$ 102,863
119	Middlesex	43.33%	$ 10,000	7,646	$ 17,646
121	Montgomery	28.34%	$ 53,993	21,353	$ 75,346
125	Nelson	31.32%	$ 12,721	5,801	$ 18,522
127	New Kent	43.29%	$ 10,000	7,634	$ 17,634
131	Northampton	19.71%	$ 16,058	3,943	$ 20,001
133	Northumberland	33.04%	$ 26,805	13,226	$ 40,031
135	Nottoway	26.86%	$ 15,650	5,748	$ 21,398
137	Orange	40.83%	$ 28,277	19,516	$ 47,793
139	Page	28.65%	$ 85,046	34,157	$ 119,203
141	Patrick	25.39%	$ 14,002	4,766	$ 18,768
143	Pittsylvania	23.55%	$ 47,385	14,600	$ 61,985
145	Powhatan	43.42%	$ 15,674	12,027	$ 27,701
147	Prince Edward	22.32%	$ 16,569	4,760	$ 21,329
149	Prince George	37.16%	$ 20,374	12,048	$ 32,422
153	Prince William	34.14%	$ 779,745	404,172	$ 1,183,917
155	Pulaski	29.23%	$ 42,149	17,405	$ 59,554
157	Rappahannock	41.99%	$ 10,000	7,238	$ 17,238
159	Richmond County	32.27%	$ 10,000	4,765	$ 14,765
161	Roanoke County	43.97%	$ 125,436	98,436	$ 223,872
163	Rockbridge	23.36%	$ 29,110	8,874	$ 37,984
165	Rockingham	34.45%	$ 56,811	29,862	$ 86,673
167	Russell	18.94%	$ 31,345	7,323	$ 38,668
169	Scott	31.54%	$ 21,525	9,917	$ 31,442
171	Shenandoah	35.17%	$ 49,463	26,828	$ 76,291
173	Smyth	23.37%	$ 97,251	29,658	$ 126,909
175	Southampton	32.30%	$ 16,488	7,868	$ 24,356
177	Spotsylvania	45.88%	$ 45,762	38,788	$ 84,550
179	Stafford	44.39%	$ 55,493	44,304	$ 99,797
181	Surry	39.79%	$ 10,000	6,609	$ 16,609
183	Sussex	23.87%	$ 31,610	9,913	$ 41,523
185	Tazewell	24.55%	$ 59,097	19,234	$ 78,331
187	Warren	38.53%	$ 23,306	14,608	$ 37,914
191	Washington	27.60%	$ 36,352	13,858	$ 50,210
193	Westmoreland	30.25%	$ 15,606	6,770	$ 22,376
195	Wise	27.55%	$ 51,186	19,463	$ 70,649
197	Wythe	27.08%	$ 28,842	10,711	$ 39,553

ID	Locality Name	Local Pool Fund Base Match Rate	FY2022 State Max Protected Funds	FY2022 Local Match	Total Protected Funds
199	York	38.88%	$ 41,320	26,290	$ 67,610
510	Alexandria	53.09%	$ 94,680	107,156	$ 201,836
520	Bristol	25.47%	$ 61,541	21,029	$ 82,570
530	Buena Vista	23.29%	$ 71,863	21,818	$ 93,681
540	Charlottesville	30.68%	$ 391,582	173,329	$ 564,911
550	Chesapeake	37.15%	$ 390,418	230,807	$ 621,225
570	Colonial Heights	40.27%	$ 14,520	9,789	$ 24,309
580	Covington	24.96%	$ 18,306	6,089	$ 24,395
590	Danville	22.23%	$ 198,162	56,631	$ 254,793
620	Franklin City	37.10%	$ 13,679	8,070	$ 21,749
630	Fredericksburg	34.41%	$ 42,729	22,417	$ 65,146
640	Galax	31.46%	$ 10,000	4,590	$ 14,590
650	Hampton	32.23%	$ 324,777	154,437	$ 479,214
660	Harrisonburg	38.08%	$ 21,137	13,001	$ 34,138
670	Hopewell	26.67%	$ 71,270	25,925	$ 97,195
678	Lexington	33.02%	$ 10,000	4,930	$ 14,930
680	Lynchburg	27.36%	$ 375,907	141,619	$ 517,526
683	Manassas City	41.68%	$ 139,978	100,022	$ 240,000
685	Manassas Park	42.73%	$ 10,000	7,462	$ 17,462
690	Martinsville	33.21%	$ 25,799	12,829	$ 38,628
700	Newport News	27.73%	$ 990,310	379,988	$ 1,370,298
710	Norfolk	24.55%	$ 1,097,638	357,116	$ 1,454,754
720	Norton	32.54%	$ 10,000	4,823	$ 14,823
730	Petersburg	35.35%	$ 114,304	62,500	$ 176,804
735	Poquoson	27.87%	$ 10,000	3,864	$ 13,864
740	Portsmouth	26.05%	$ 152,670	53,780	$ 206,450
750	Radford	20.35%	$ 10,000	2,554	$ 12,554
760	Richmond City	36.91%	$ 652,624	381,766	$ 1,034,390
770	Roanoke City	30.72%	$ 484,023	214,653	$ 698,676
775	Salem	35.13%	$ 22,237	12,042	$ 34,279
790	Staunton	26.99%	$ 102,927	38,041	$ 140,968
800	Suffolk	24.32%	$ 309,218	99,379	$ 408,597
810	Virginia Beach	35.69%	$ 1,073,425	595,674	$ 1,669,099
820	Waynesboro	38.43%	$ 44,282	27,639	$ 71,921
830	Williamsburg	45.53%	$ 10,000	8,359	$ 18,359
840	Winchester	45.87%	$ 20,162	17,088	$ 37,250
1200	Greensville/Emporia	22.66%	$ 64,731	18,963	$ 83,694
1300	Fairfax/Falls Church	46.11%	$ 1,630,458	1,395,310	$ 3,025,768
	Statewide		$ 14,464,225	**$ 7,783,468**	**$ 22,247,693**

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

http://www.dmas.virginia.gov

MEDICAID BULLETIN

TO: Psychiatric Residential Treatment Facilities, Medallion 4.0 and Commonwealth Coordinated Care (CCC) Plus Managed Care Plans

FROM: Karen Kimsey, Director
Department of Medical Assistance Services (DMAS)

DATE: 5/28/2021

SUBJECT: Residential Treatment Facility Rate Changes - Effective July 1, 2021

The purpose of this bulletin is to inform Psychiatric Residential Treatment Facilities (PRTFs), Residential Levels of Care for the American Society of Addiction Medicine (ASAM) including Medically Monitored Intensive Inpatient Services (Adult), Medically Monitored High Intensity Inpatient Services (Adolescent) (ASAM Level 3.7), Clinically Managed High-Intensity Residential Services (Adult) and Clinically Managed Medium-Intensity Residential Services (Adolescent) (ASAM Level 3.5) and Clinically Managed Population-Specific High Intensity Residential Service (ASAM Level 3.3) facilities of rate changes mandated by the 2021 Appropriation ACT. All rate changes are effective July 1, 2021.

In accordance with Item 313.CC of the 2021 Appropriation ACT, DMAS will revise the per diem rates paid to Virginia-based PRTFs and Residential ASAM Level 3.3/3.5/3.7 facilities using the provider's audited cost per day from the facility's cost report for provider fiscal years ending in state fiscal year 2018. New Virginia-based residential treatment facilities must submit proforma cost report data, which will be used to set the initial per diem rate based on an audited cost report for a 12-month period within the first two years of operation.

If necessary to enroll out-of-state providers for network adequacy, the department shall negotiate rates. If there is sufficient utilization, the department may require out-of-state providers to submit a cost report to establish a per diem rate.

In-state and out-of-state provider per diem rates shall be subject to a $423.32 rate ceiling based on the statewide weighted average cost per day based on data from fiscal year 2018 cost reports.

Virginia-based Residential Treatment Facilities that do not submit cost reports shall be paid at 75 percent of the established rate ceiling.

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and administration of the fee for service (FFS) behavioral health

benefit programs under contract with DMAS, including those for PRTFs. For more information about Magellan of Virginia, please consult Magellan's National Provider Handbook, the Magellan Virginia Provider Handbook, contact Magellan of Virginia at (800) 424-4536 or VAProviderQuestions@MagellanHealth.com, or visit http://www.magellanofvirginia.com.

For questions regarding residential treatment facility rates and to get instructions on how to submit cost reports, please contact Taryn Gulkewicz at (804) 786-0037 or email Taryn.Gulkewicz@dmas.virginia.gov.

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PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal **Automated Response System (ARS)** Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-for-service members.	https://dmas.kepro.com/
Provider Appeals DMAS is launching an appeal portal in late May 2021. You can use this portal to file appeals and track the status of your appeals. Visit the website listed for appeal resources and to register for the portal.	https://www.dmas.virginia.gov/#/appealsresources
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms

Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or Call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627
Aetna Better Health of Virginia	www.aetnabetterhealth.com/Virginia 1-800-279-1878
Anthem HealthKeepers Plus	www.anthem.com/vamedicaid 1-800-901-0020
Magellan Complete Care of Virginia	www.MCCofVA.com 1-800-424-4518 (TTY 711) or 1-800-643-2273
Optima Family Care	1-800-881-2166 www.optimahealth.com/medicaid
United Healthcare	www.Uhccommunityplan.com/VA and www.myuhc.com/communityplan 1-844-752-9434, TTY 711
Virginia Premier	1-800-727-7536 (TTY: 711), www.virginiapremier.com

CC. Effective July 1, ~~2020~~ *2021*, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to revise per diem rates paid to Virginia-based psychiatric residential treatment facilities using the provider's audited cost per day from the facility's cost report for provider fiscal years ending in state fiscal year 2018. New Virginia-based residential psychiatric facilities must submit proforma cost report data, which will be used to set the initial per diem rate for up to two years. After this period, the department shall establish a per diem rate based on an audited cost report for a 12-month period within the first two years of operation. Virginia-based residential psychiatric facilities that do not submit cost reports shall be paid at 75 percent of the established rate ceiling. If necessary to enroll out-of-state providers for network adequacy, the department shall negotiate rates. If there is sufficient utilization, the department may require out-of-state providers to submit a cost report to establish a per diem rate. In-state and out-of-state provider per diem rates shall be subject to a ceiling based on the statewide weighted average cost per day from fiscal year 2018 cost reports. The department shall have the authority to implement these changes effective July 1, ~~2020~~ *2021* and prior to the completion of any regulatory process undertaken in order to effect such change.

Facility Name			Ceiling **		Rates with Ceiling Applied
ALICE C TYLER VILLAGE OF CHILDHELP			$ 423.32		$ 423.32
BARRY ROBINSON CENTER					$ 423.32
BRIDGES TREATMENT CENTER					$ 423.32
CUMBERLAND HOSPITAL LLC (PRTF ONLY)					$ 423.32
FAIR WINDS					$ 423.32
GRAFTON SCHOOL INC					$ 423.32
HALLMARK YOUTHCARE - RICHMOND					$ 423.32
HARBOR POINT BEHAVIORAL HEALTH CENTER INC					$ 345.17
JACKSON FIELD HOMES					$ 423.32
KEMPSVILLE CENTER FOR BEHAVIORAL HEALTH					$ 327.86
KEYSTONE NEWPORT NEWS					$ 299.73
LIBERTY POINT BEHAVIORAL HEALTH					$ 423.32
NORTH SPRING BEHAVIORAL HEALTH					$ 397.96
POPLAR SPRINGS HOSPITAL (PRTF ONLY)					$ 423.32
THE HUGHES CENTER FOR EXCEPTIONAL CHILDREN					$ 386.88
THREE RIVERS TREATMENT CENTER LLC					$ 423.32
TIMBER RIDGE SCHOOL					$ 423.32
UNITED METHODIST FAMILY SERVICES OF VA					$ 423.32
YOUTH FOR TOMORROW - NEW LIFE CENTER INC					$ 423.32

** Taken from Medicaid Residential Treatment Centers Rate Study, Table 1, Weighted Average Program RTF Cost Per Day

State Executive Council for Children's Services (SEC)

Notice of Intent to Develop Policy (SEC Policy 3.3)

Title of Proposed Policy:

Family Engagement

Intended Action:

Revision of existing Policy 3.3, adopted March 25, 2010

Background and Summary:

Family engagement is cornerstone of the system of care philosophy at the heart to the Children's Services Act. Successful family engagement is well-established as a critical component of effective outcomes for service delivery systems.

The State Executive Council for Children's Services adopted its initial family engagement policy over ten years ago. The policy has not been reviewed or revised since that time. The existing policy needs to be updated to reflect current best practices and conceptualizations regarding this important issue.

This proposed policy was developed by the SEC Policy Review Workgroup established to support the Strategic Plan of the State Executive Council for Children's Services.

Intent of Proposed Revisions: The proposed revisions will:

- Update the policy to reflect the format and organization of current SEC policies
- Update the policy to reflect current understanding of the definitions and meaning of "family"
- Provide definitive Values Statement reflecting the beliefs in the CSA in family-centered practices and the System of Care
- Eliminate obsolete sections and requirements and replace them with current best practice with regard to engaging families in the CSA-process
- Specify reasonable expectations for local CSA programs with regard to family engagement while retaining local flexibility and autonomy in the implementation of those expectations
- Specify expectations for the Office of Children's Services in providing resources to support local CSA programs in the successful implementation of the revised policy

Date of SEC Action: June 10, 2021

Stage: Notice

Public Comment Period: June 14 – July 16, 2021 (30 days)

Date/Stage of Next SEC Action: September 9, 2021 – Proposed Stage for a minimum of 60 days of public comment.

Public Comment will be accepted through the Public Policy Comments Form (https://www.csa.virginia.gov/doecsa123) on the CSA website: www.csa.virginia.gov

Individuals wishing to be placed on the CSA Notification List should make such request via e-mail to csa.office@csa.virginia.gov

State Executive Council for Children's Services (SEC)

Notice of Intent to Develop Policy (SEC Policy 3.2)

Title of Proposed Policy:

Family Assessment and Planning Team

Intended Action:

Revision of existing Policy 3.2, adopted March 25, 2010

Background and Summary:

This policy was adopted by the State Executive Council for Children's Services in 2010 and has not been reviewed or revised.

The proposed revisions to the policy include technical changes (format and organization) as well as substantive changes to the section regarding Alternate Multidisciplinary Teams that may be employed by local CSA programs in lieu of the Family Assessment and Planning Team (FAPT). That section of the existing policy would benefit from additional detail and clarity of content..

This proposed policy is under review by the SEC Policy Review Workgroup established to support the Strategic Plan of the State Executive Council for Children's Services. The actual text of the revised policy will be developed by that workgroup for consideration at the next stage of the policy-making process.

Intent of Proposed Revisions: The proposed revisions will:

- Update the policy to reflect the format and organization of current SEC policies
- Clarify the expectations for the alternative multidisciplinary teams

Date of SEC Action: June 10, 2021

Stage: Notice

Public Comment Period: June 14 – July 16, 2021 (30 days)

Date/Stage of Next SEC Action: September 9, 2021 – Proposed Stage for a minimum of 60 days of public comment.

Public Comment will be accepted through the Public Policy Comments Form (https://www.csa.virginia.gov/doecsa123) on the CSA website: www.csa.virginia.gov

Individuals wishing to be placed on the CSA Notification List should make such request via e-mail to csa.office@csa.virginia.gov